

**THE HEALTH CARE FINANCING SYSTEM  
AND THE UNINSURED**

*Submitted to:*

**Office of Research  
Health Care Financing Administration  
Department of Health and Human Services**

*Submitted by:*

**Lewin/ICF**  
*a division of Health and Sciences International*

1090 Vermont Avenue, N.W.  
Suite 700  
Washington, D.C. 20005

**December 22, 1989**



**LEWIN / ICF**

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## PREFACE

The Presidential AIDS Commission called attention to major gaps in the nation's health care financing system. While the Commission's principal focus was on those afflicted with HIV infection, the Commission's 1988 hearings on finance underscored that the insurance problems of the AIDS population were not unique, but were shared by other populations with special health care needs. Likewise, the Commission found the problems of access for the AIDS population were shared by other populations with special needs, the uninsured, and the underinsured. The Commission called for further analysis of the problems of financing and access and an analysis of options to address those problems. In this call, the Presidential AIDS Commission added its voice to those of special task forces, academics, state legislatures and governors, and a myriad of private interest groups who have called attention to these issues.

The Health Care Financing Administration (HCFA) sponsored this study of the Health Care Financing System and the Uninsured in response to the Presidential AIDS Commission. This study assesses the problems of the uninsured, underinsured, and persons at risk of incurring catastrophic expenses, and provides an analysis of the impact of alternative policy approaches on these problems and other aspects of the health care financing system.

The study is organized in two parts:

- **Part One: Gaps in Coverage and Sources of Care for the Uninsured, Underinsured, and Persons with High-Expense Illness**, which provides a synthesis of existing information as well as new analysis of these issues.
- **Part Two: Analysis of Alternative Proposals to Extend Health Insurance**, which examines the impact of selected proposals to improve access to care, the resulting extent and sources of insurance coverage, and financial impacts on families, government, and employers.



This study benefited from the assistance of many individuals who provided insight into aspects of the problem of the uninsured and underinsured. We especially want to thank our HCFA Project Officers, Lu Zawistowich and Jerry Riley, who guided the project and provided valuable critique of our draft reports. Others at HCFA who provided guidance to this project are Marian Gornick and James Lubitz from the Division of Beneficiary Studies, David Baugh and Penelope Pine of the Division of Program Studies, and Ross Arnett, Mark Freeland, John Klemm, and Sally Sonnefeld of the Office of the Actuary. Chris Bladen of the Office of the Assistant Secretary for Planning and Evaluation, Patricia Willis of the Department of Labor, and Alan Monheit of the National Center for Health Services Research also made substantial contributions to our work.

In addition, we wish to thank the members of our Technical Advisory Panel for their thoughtful comments at all stages of the project. They include Gail Wilensky, Katherine Swartz, Diane Rowland, Deborah Lewis-Idema, Patricia Butler, and Arlene Leibowitz. Also, Marilyn Rymer, Ed Neuschler, Kenneth Thorpe, and Joseph Newhouse, who served as consultants to the project, provided valuable contributions. Dr. Thorpe, in addition to reviewing draft reports, provided the methods used to analyze adopting a uniform benefit package under Medicaid.

This report was prepared by Jack Needleman, Judith Arnold, John Sheils, Larry Lewin, Jessica Miller and Kristi Merritt of Lewin/ICF. Mr. Sheils also conducted the analysis for this project using the Health Benefits Simulation Model, which was developed by Mr. Sheils and Dr. Joseph Anderson of Lewin/ICF. Production of this report was coordinated by Rhonda Greene.

## EXECUTIVE SUMMARY

The rapid growth in the number of persons with AIDS has heightened awareness of the gaps in financing health care for the uninsured, underinsured, and persons with high-expense illness. The 1988 Presidential AIDS Commission highlighted problems in access to health care for persons with HIV infection, and also noted that these problems were reflections of problems for the uninsured and underinsured in general. It called for a study to analyze the health care financing system and examine the impact of options to expand insurance. This study, sponsored by the Health Care Financing Administration, assesses the problems of the uninsured, underinsured, and persons at risk of incurring catastrophic expenses, and provides an analysis of the impact of alternative policy approaches on these problems and other aspects of the health care financing system.

Our analysis of the problems in the health care financing system found that 31.8 million Americans have no public or private health insurance. Those most likely to be uninsured are children, males, hispanic and nonwhite persons, the poor, the unemployed, and persons who report themselves to be in poor health. However, because some of these segments of the population are small, more of the uninsured are: adults, employed or dependents of employed persons, and persons who report themselves to be in good or excellent health. The uninsured are not entirely without access to health services; they do, however, use significantly fewer services than insured populations. Total health care expenditures for uninsured persons would increase by about one-third (\$10.7 billion) if their utilization of physicians, hospitals, and prescription drugs matched the level of the insured. The uninsured only pay out-of-pocket for about half of the care they receive. The remainder of their care is paid by federal, state, and local support to health care providers, general assistance, cost shifting, and philanthropy and this makes the uninsured more dependent on providers, such as hospitals, who can obtain these funds to subsidize their care. Since 1980, while the number of uninsured has risen substantially, public funding for direct services has grown more slowly than health spending in general.

A wide variety of options have been proposed to extend insurance coverage to the uninsured. These options vary in the number of uninsured who become insured and the characteristics of those becoming insured. Some options result in large shifts of sources of insurance among insured populations as well, with many people dropping nongroup coverage in favor of Medicaid or employment-based insurance. Proposals vary in how they are financed and the relative distribution of financing among the major payors, such as government, employers, and individuals. Table 1 summarizes the impact of selected options to expand insurance coverage on the number of persons who remain uninsured and the costs to government, business, and families.

The remainder of the Executive Summary is divided into two sections. Section A summarizes the problems of the uninsured, underinsured, and persons with high-expense illness and reviews the performance of the health care financing system. Section B summarizes the results of the analysis of options to expand Medicaid and employer-based coverage. A full description of the options analysis is in Part Two of the report.

Table 1

Impact of Options to Expand Health Insurance on the Number of Uninsured  
and Costs to Government, Employers, and Families

Option	Remaining Uninsured (in millions)	Sources of Payment (in billions)			a/
		Government	Employers	Families	
Illustrative Medicaid Expansion Package	24.6	11.9	0	(8.1)	
Medicaid Buy-in	21.3	13.7	0	(9.1)	
Employer Mandate with Specified Benefits	6.2	(6.7)	29.5	(12.0)	
Employer Mandate with Medicaid Expansion (full participation/ universal coverage)	0	17.7	26.4	(26.7)	
"Pay or Play" Tax Incentive (universal coverage)	0	37.4	10.5	(23.2)	

a/ Includes health benefit payments only. Excludes administrative costs.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



## A. GAPS IN COVERAGE AND SOURCES OF CARE FOR THE UNINSURED, UNDERINSURED, AND PERSONS WITH HIGH-EXPENSE ILLNESS

Part One of this report assesses how well the current health care system is performing. To accomplish this it examines the system first from the perspective of individuals or families without coverage, providing information on the number of uninsured, their characteristics, and the consequences of a lack of adequate health insurance. The report then analyzes the issue from the perspective of the health care financing system as a whole, describing how health care for the insured and uninsured is currently financed, why the uninsured lack coverage, and recent efforts to expand insurance coverage.

### 1. The Size of the Uninsured Population

The number of uninsured increased substantially from 1980 to 1984, and has remained constant since 1984. The number of uninsured was estimated in the CPS at 28.8 million in 1979, and 37.3 million in 1984, a 30 percent increase. The increase in the percentage of the population lacking health insurance appears to have been associated with the economic recession which occurred during the early 1980s. Rising uninsurance rates seem to parallel increases in unemployment. However, as the economy recovered from the recession, and employment increased, the number of uninsured persons did not decline. While the reasons are not completely clear, explanations offered include increases in employment in service industries where the percentage of employers offering health insurance is relatively low. Other possible explanations include the decline in the Medicaid-eligible population, the increase in the number of Americans with incomes below the poverty level, and changes in employer health plans which require greater employee cost sharing.

Based on the March 1988 Current Population Survey (CPS), an estimated 31.8 million Americans, or 13.2 percent of the United States population, had no public or private health insurance in 1987. This estimate is substantially different from earlier estimates from the CPS, e.g., 37.3 million uninsured persons reported for 1986. The apparent decline in the number of

uninsured is generally attributed to changes in the design of the CPS questionnaire that improve the accuracy of the health insurance estimates and not to a decline in the number of uninsured. While the estimate of 31.8 million may be revised, at this time the 1988 CPS is the most current and appropriate data available for analyzing the number and characteristics of the uninsured.

## 2. Characteristics of the Uninsured Populations

The characteristics of the 31.8 million uninsured persons are presented in Table 2. The table presents both the probability of those within a group not having insurance, and the proportion of the uninsured represented by that group.

## 3. The Size of the Underinsured Population

Estimates of the number of persons in private health insurance plans who are underinsured range from 12 to 20 million persons depending upon which definitions of underinsurance are used. The number of underinsured tends to be greatest in firms with fewer than 25 employees. In addition, persons enrolled in non-group plans were generally more likely to be underinsured than were persons insured under group plans. The number of underinsured increased with age, with females twice as likely to be underinsured as males.

During the past decade, employers have made a number of changes to their health plans that may change the number of underinsured. More employers are offering major medical coverage that limits the total amount that must be paid in coinsurance and deductibles, and this extension of major medical coverage has likely reduced the rate of underinsurance. At the same time, employers have increased the amount of front-end cost sharing required by the worker either in the form of higher premiums or increased coinsurance and deductibles, and thus may have rendered some low-income persons underinsured. The actual impact of these trends on underinsurance is unclear.

Table 2  
Characteristics of the Uninsured

	Number of Uninsured Persons (in millions)	Percentage of All Uninsured	Uninsured as Percentage of Persons in Group
All Persons	31.8	100.0%	13.2%
Age of Individual			
Less than 6	3.0	9.4	13.6
Age 6-17	5.9	18.6	14.3
Age 18-21	3.0	9.4	20.9
Age 22-24	3.1	9.8	26.6
Age 25-34	7.2	22.7	16.8
Age 35-44	4.2	13.1	12.0
Age 45-54	2.7	8.5	11.4
Age 55-64	2.4	7.6	11.2
Age 65+	0.3	0.8	0.9
Sex of Individual			
Male	16.9	53.2	14.4
Female	14.9	46.8	12.0
Race/Ethnicity			
White	24.7	77.5	12.1
Non-white	7.2	22.5	19.2
Hispanic	6.1	19.2	31.4
Income as Percent of Poverty			
Below Poverty	9.5	30.0	29.1
100-149%	5.7	17.8	25.8
150-199%	4.4	13.8	19.4
200-299%	5.6	17.6	12.2
300% or more	6.6	20.9	5.6

Source: Preliminary estimates from the March 1988 Current Population Survey data, July 1, 1989. Subject to revision.



#### 4. Consequences of Uninsurance and Underinsurance

While it is often stated that the uninsured do not have access to the health care system, this is an overstatement. Both the uninsured and underinsured use a substantial amount of health services, although there may still be a gap between the amount of services used and the amount of care needed. The problems faced by the uninsured and underinsured when they need care may be problems of access or financial burden. To examine the consequences of being uninsured, it is useful to review the experience of these individuals and families when they confront a health problem. They have three choices: 1) postponing or foregoing care; 2) paying out-of-pocket; and 3) seeking care at reduced or no charge. Analyses suggest they exercise all three choices. Each of these decisions have specific implications for the families in terms of access to care, health status, and financial status.

##### a. Postponed or foregone care

Considerable evidence suggests that the uninsured and underinsured receive less care than the insured or similar age, race, and health status and that they postpone or forego care:

- Spending on health care for the uninsured is substantially less than for the insured (in 1988, \$866 per capita compared with \$1,457 for the insured). Spending was lower for every type of service.
- The uninsured are more likely to indicate that they did not receive care they needed and cite financial factors as the reason. They are also less likely to have a usual source of care and rely to a greater extent on hospital-based sources of care.
- At all age levels and adjusting for health status, the uninsured have substantially fewer physician office visits and hospital admissions per person than do insured persons, and obtain fewer prescription drugs.
- The uninsured obtain fewer preventive services than the insured and while having lower hospitalization rates in general, have higher rates of avoidable hospitalizations for preventable conditions.

### b. Out-of-pocket payments

The second option facing the uninsured is to pay for care out-of-pocket. While average out-of-pocket expenditures for the uninsured are less than for the insured, they are substantial. We estimate that out-of-pocket expenditures per person in 1988 were \$430 for uninsured persons and \$463 for persons with insurance. This pattern holds at all income levels

Out-of-pocket expenditures, while lower for the uninsured in dollar terms, are higher as a percentage of family income. Moreover, the risk of incurring high medical expenses as a percent of income is greater in families without insurance.

Out-of-pocket spending for the uninsured is lower than among those with insurance for several reasons: 1) the uninsured use fewer health care services than do those with insurance; 2) the uninsured do not bear a share of premium costs for their insurance; and 3) the uninsured pay out-of-pocket for only about half of the care they receive. (The rest of their care is paid by charity care and other public sources.)

### c. Reduced or no charge care

The third option available to the uninsured and underinsured is to seek care at reduced or no charge from providers who are willing to discount their charges. These may include hospitals, community health centers, public health departments, physicians, and other providers. This discounted care is financed by government, philanthropy, and cost shifting.

Half the cost of the health services of the uninsured are paid by others. HCFA reports that in 1987 federal, state, and local spending for personal health services outside of public insurance such as Medicare or Medicaid was \$45 billion, over 10 percent of personal health spending. Other private spending, including philanthropy, was \$2.7 billion, almost all for hospital care. In addition, a substantial amount of discounted care is paid

for through cost shifts to other patients or reduced net income of health care providers. It is estimated that for 1989 hospital bad debt and charity care would be \$9.6 billion. No reliable estimates are available for the extent of discounted care by physicians.

One of the consequences of lack of insurance is a greater reliance on providers who can obtain the resources to subsidize care. Often, these are hospitals. A larger portion of the health care expenditures of the uninsured were for hospital services than the insured. The uninsured also rely on free care sources (public hospitals and clinics) to a greater extent than the low income insured.

#### d. The cost of closing the access gap for the uninsured

The uninsured account for approximately 11 percent of all personal health care expenditures by non-institutionalized persons under the age of 65. While the uninsured consume a substantial amount of health care, they face barriers to care and their per capita health spending is less than the insured.

Total health care expenditures for uninsured persons would increase by about one-third if their utilization matched the level of the insured. If the uninsured were covered under a health plan covering physician care, hospital inpatient and outpatient care, and prescription drugs, and their utilization of these services rose to the level of the insured, their expenditures for personal health care services would rise from about \$31.9 billion to \$42.6 billion, an increase of \$10.7 billion. This is one estimate of the shortfall in health expenditures of uninsured persons.

### 5. Financing Care for the Insured and Uninsured

The discussion above has focused on the issue of uninsurance principally from the prospective of defining who the uninsured are and the consequences for them of being uninsured. The focus is now shifted to the



health care financing system to examine from what sources individuals obtain health insurance, why individuals are or are not insured, how services are funded, and recent initiatives to expand access to insurance. This section reviews the scope of third-party financing as a prelude to the discussion of how the limits of insurance influence who obtains coverage.

#### a. Insurance

The American health insurance system is based largely on private group health insurance for the employed and public sector coverage for the elderly and certain categories of the disabled and the poor, supplemented by other public and private insurance mechanisms, most notably non-group insurance. The sources and limitations of insurance are presented in Table 3.

Table 3  
Source of Insurance Coverage in 1987

Source	Number (in millions)	Percent of Total Population	Limitations
Medicare	30.4	12.6	No coverage for outpatient prescription drugs and most forms of preventive care; limits on hospital and physician services; 24-month waiting period for disabled persons on SSDI.
Medicaid	20.7	8.6	Eligibility and benefits vary by state; limited to certain categories of the poor.
Employer-based	148.2	61.4	High cost for small firms; some employees excluded from coverage; coverage for dependents may be unaffordable.
Non-group Insurance	31.7	13.1	High cost; exclusions for certain health conditions.

Source: Preliminary estimates from the March 1988 Current Population Survey data, June 30, 1989. Subject to revision.

## b. Directly financed services

Much of the health care for the uninsured and underinsured is financed by grants or appropriations directly to providers, although the same providers may also be reimbursed by insurance as well. Government is a principal source of funding for direct services. Government-financed programs for personal health services other than Medicare and Medicaid paid for \$45 billion in health care in 1987. Private philanthropy is also estimated to provide \$2.7 billion for these services. The sources of financing for these services vary by the type of service:

- **Hospital.** Public hospitals provide a large amount of care to the uninsured financed by direct grants from state or local governments. Both public and private hospitals receive contracts to provide certain services to the poor, such as under the Maternal and Child Health Block Grant.
- **Physician Services.** Federal, state, and local governments finance a number of organized primary care centers that provide services to the uninsured. These include federally funded community and migrant health centers and public health clinics.
- **Prescription drugs.** Access to prescription drugs is a problem for many of the uninsured, particularly those with chronic conditions. Some states have programs to subsidize the cost of drugs for certain populations. Most are limited to the elderly.
- **Other Services.** Some federal and state money is also available for other services needed by low-income persons, such as transportation, nutrition counseling, and other support services.

## c. Implicit subsidies and cost shift

In addition to support through public funding and philanthropy, charity care by hospitals, physicians, and other providers traditionally has been financed through cross-subsidies from privately insured patients. Hospitals in particular have charged more to insured patients to help finance unpaid bills. Estimates of total charity care are not available, but the cost of uncompensated care provided by hospitals in 1989 was estimated at \$9.6 billion. Estimates of charity care by physicians are not available.



## 6. Why the Uninsured and Underinsured Lack Coverage

Why do approximately 32 million Americans lack any form of public or private health coverage and many million more have inadequate coverage? For some, particularly the working poor, insurance is often not available through their employers, and the cost of purchasing a non-group insurance plan is prohibitive. For many of the poor, eligibility limitations and enrollment inefficiencies prevent access to public insurance programs. For some higher income uninsured, lack of coverage may be a matter of personal choice, or lack of access to insurance due to their health status. Five factors play a substantial role in determining who is uninsured:

- **Many Employers Do Not Offer Health Benefits.** Many employers, particularly small employers, do not offer health benefits. Over one-half of all workers who do not have employer health insurance are employed in firms with fewer than 10 employees. A large number are self-employed. Workers who lack health insurance are more likely to be part-time and earn low wages. In considering the reasons employers do not provide insurance, most cite insufficient profits and the high cost of insurance as the primary reasons. Secondary reasons include job turnover and the lack of available insurance. Health insurance is generally more expensive for small employers. This reflects higher administrative costs associated with servicing small groups and the addition to the premium of a factor for increased risk associated with the lack of experience rating for the individual group.
- **Employee Exclusion or Refusal to Accept Employer Coverage.** Both large and small employers exclude some workers from coverage. Approximately 68 percent of all employers exclude part-time workers. Many employers contribute less to the cost of the premium for dependents than for employees. Some plans exclude persons with certain medical conditions, and it is claimed that more plans are excluding those with preexisting conditions than in the past. Approximately 13 percent of workers who are offered coverage do not accept it.
- **The Limits of Non-Group Insurance.** Some of the uninsured who do not qualify for Medicaid and cannot obtain coverage through their employers are able to purchase non-group insurance coverage. For many, the cost of non-group coverage is prohibitive. Those with certain medical conditions, such as diabetes, heart disease, asthma, or AIDS may be rejected as uninsurable when they apply for non-group policies. The 16 states with high-risk pools allow individuals who are otherwise uninsurable to purchase non-group coverage. Enrollment in such programs is low, with only about 10

percent of those estimated to be uninsurable enrolled in these programs. In 11 other states, Blue Cross plans serve as de facto risk pools by offering open enrollment on an ongoing or periodic basis.

- **Limits of Medicaid Coverage.** Although the Medicaid program was designed to provide access to medical care for certain groups of low income individuals, it does not cover all of the poverty population. States have considerable flexibility in setting their Medicaid eligibility policies. Because of this, where people live makes a difference in whether they are eligible for Medicaid. Some persons do not meet the income eligibility levels for the program. Others meet the income limits but do not meet the categorical requirements. Finally, many of those who are eligible for Medicaid do not enroll in the program.
- **The Personal Choice to Remain Uninsured.** Some of the uninsured choose not to obtain health insurance either by not enrolling in Medicaid or by not accepting employer-based coverage. Approximately 28 percent of those who are eligible for Medicaid do not enroll. About 13 percent of persons offered employer-based coverage do not accept it.

## 7. Public and Private Efforts to Expand Insurance

In recent years a number of initiatives have been undertaken to expand access to insurance. At the federal level, these have focused on Medicaid expansion, and assuring access to Medicare Part B for the poor, elderly, and disabled. State and local level programs have focused on Medicaid, employer-based insurance, and expanding non-group insurance. These expansion efforts have included:

- **Medicaid Expansion.** In the past few years, Congress has passed a number of expansions to the Medicaid program. These have focused on expanding eligibility for pregnant women and children, and expanding Medicaid buy-in to Medicare for the SSI population. Many of these are optional for the states; a number are mandatory.
- **Requirements for Employer-based Insurance.** Two states have requirements for employers to provide insurance to their employees. Hawaii mandates employer coverage and Massachusetts, as part of its Health Security Act of 1988, will levy a tax penalty on employers who do not provide insurance as of January 1, 1992. A New York proposal (UNY\*Care) would require that all employers provide health insurance to their employees.



- **Efforts to Increase Employer Access to Insurance.** A number of efforts are being aimed at reducing the cost of insurance to small employers. These include Multiple Employer Trusts whereby small employers group together for the purchase of insurance coverage, and tax credits for small employers who provide insurance. In addition, a number of specific programs are underway to increase employer access to insurance, such as the Robert Wood Johnson Demonstration Projects and the New York Employer Incentive Program which subsidizes employer-based coverage.
- **Assisting Individuals in Obtaining Coverage.** A number of strategies are available to assist individuals in obtaining coverage:
  - **Risk Pools.** Sixteen states have established risk pools for the medically uninsurable or enacted legislation to establish a pool. These risk pools offer health insurance to people who are otherwise unable to purchase it. Enrollment in the risk pools has been low. In all states, enrollment is less than 3 percent of the uninsured in the state. Low enrollment is largely due to high premiums. The Maine and Wisconsin risk pools include a provision to subsidize the premium for low income enrollees.
  - **Catastrophic Programs.** During the 1970s, four states (Alaska, Maine, Minnesota, and Rhode Island) created general catastrophic programs to protect individuals and their families from being financially devastated by large medical bills. Only the Rhode Island program is still operational. Recently New Jersey and New York established catastrophic programs. The other programs were discontinued largely because they served few people and monies were reallocated to other programs.
  - **State Requirements for Blue Cross/Blue Shield Plans.** In 11 states the Blue Cross/Blue Shield plans offer non-group coverage with open enrollment, no age-adjustment of the premiums, and no exclusions of persons with certain medical conditions. This provides a greater opportunity for persons who might be regarded as uninsurable to obtain coverage and serves as an alternative to a state high risk pool.
  - **State Subsidized Non-group Insurance.** Some states have developed state-subsidized non-group insurance products, often as pilot projects. Examples include the Washington Basic Health Plan, the Robert Wood Johnson Foundation Insurance Demonstrations, the New York Individual Subsidy Program, and the Minnesota Healthspan Program.

## 8. Conclusion

The issues that have been raised in Part One address four dimensions of the current health care system: 1) whether the uninsured have access to sufficient care; 2) whether the care they receive is efficiently provided; 3) whether the financial burden of paying for this care is equitably distributed; and 4) whether the current system is stable, or whether access and financing are at risk. These dimensions can be used to assess options for expanding access to care:

- **Sufficiency.** Evidence suggests that sufficiency of care is a problem for the uninsured. The uninsured have significant shortfalls in utilization of care when compared to the insured. They also report greater barriers to access to care.
- **Efficiency.** Available information suggests that many aspects of the financing and delivery of care to the uninsured could be made more efficient. The uninsured disproportionately rely on hospital emergency rooms and outpatient departments for their primary care. Further, the lack of coverage for many primary care services causes many people to wait until they are seriously ill to seek care.
- **Equity.** The financing and delivery of health care is disproportionately distributed among providers and payors. Some providers serve a disproportionate share of the uninsured. On the payor side, government financing and payments by large employers are the two principal sources of insurance. Many individuals, including low income individuals, bear all or most of the costs of non-group insurance without a contribution by their employers or government.
- **Stability.** The current health care financing system shows signs of instability. The signs include the failure of the number of uninsured to decline as employment improved, increasing limitations in employer health plans, the substantial growth in insurance costs in the small group and individual markets, increasing competition among providers, more aggressive bargaining and rate setting by payors that reduces cushions that have helped pay for uncompensated care, hospital closure in rural areas, and slow growth of public financing for direct services.

The findings presented in this synthesis on the nature and extent of the problems of the uninsured and the performance of the health care financing system have important implications for the design and analysis of options to expand insurance coverage. The next section analyzes options for expanding insurance to the uninsured.

## B. ANALYSIS OF ALTERNATIVE PROPOSALS TO EXTEND HEALTH INSURANCE

Part Two of this report describes the options analyzed for extending coverage to the uninsured and presents the results of this analysis. The options selected attempt to address the major gaps in coverage identified in Part One as well as reflect the major options being actively considered in the national policy debate. The options analyzed can be grouped into three major categories: 1) Medicaid eligibility expansion and reform; 2) Medicare eligibility expansion and reform; and 3) requirements for employer-based insurance.

Much of the analysis of these options was done using the Lewin/ICF Health Benefits Simulation Model. This model has been developed to permit analysis of national and state proposals to restructure the financing of health care. The model includes information on the number of uninsured and insured, and for the insured, their sources of coverage. It also includes demographic information on these populations, data on health care expenditures by age, sex, income, and insurance status, and out-of-pocket, employer, and government contributions to the financing of care. Proposals for extending health insurance coverage can be modeled and their impact on the number of uninsured, the sources of insurance coverage, changes in health use and health expenditures and sources of funding for care can be analyzed.

For each of the three major categories of options (Medicaid expansion, Medicare expansion, and employment-based approaches), the number of people served and program costs are presented. All the options are then compared along the following dimensions: 1) the extent to which they cover the uninsured; 2) changes in expenditures for health care services and sources of payment; and 3) the target efficiency of proposals.

### 1. Medicaid Eligibility Expansion and Reform

Expanding the Medicaid program represents a major approach to extending coverage to the uninsured. In fact, over the past few years, Congress has passed a number of expansions to the Medicaid program. These have focused on expanding eligibility for certain population groups, such as pregnant women and children, and the low-income elderly and disabled.



Five "stand alone" Medicaid expansion options and one "illustrative Medicaid expansion package" which integrates a number of the options into a single plan were analyzed. They are:

- Mandatory medically needy programs for non-institutionalized persons in all states.
- Standardized state Medicaid benefit packages using:
  - a "median" state benefit package (Washington model).
  - The "most comprehensive" benefit package (Minnesota model).
- Medicaid expansion for pregnant women and infants with incomes up to 185 percent of poverty.
- Selected national minimum income eligibility levels assuming:
  - categorical eligibility is retained.
  - categorical eligibility is eliminated.
- Medicaid buy-in for non-institutionalized persons with incomes below 185 percent of the poverty level.
- Illustrative Medicaid expansion package which combines three options above: 1) raising the eligibility level to 100 percent of poverty with categorical requirements eliminated; 2) establishing medically needy programs in all states; and 3) extending coverage to pregnant women and infants with incomes up to 185 percent of poverty.

A comparison of the number of people affected and the program costs for selected Medicaid expansion options is presented in Table 4. As would be expected, program costs increase as the number of people covered increases. On a per capita basis mandating that all states adopt medically needy programs is more expensive than any of the other options. This is because many of these persons become eligible for Medicaid by incurring large medical bills. In addition, options that raise the Medicaid income eligibility level are less costly on a per capita basis than options that eliminate categorical

Table 4

Average Monthly Enrollment and Program Costs for  
Selected Medicaid Expansion Proposals

Proposal	Average Monthly Enrollment (in millions)	Annual Program Costs (in billions)		
		Total Costs	Federal Share	State Share
Mandatory Medically Needy	1.7	\$ 2.2	\$ 1.3	\$0.9
Pregnant women and infants up to 185 percent of poverty <sup>a/</sup>	1.9	1.2	0.7	0.5
Increase eligibility level to 100 percent of poverty with categorical requirements <sup>b/</sup>	4.2	3.6	2.3	1.3
Increase eligibility level to 100 percent of poverty with categorical requirements eliminated <sup>b/</sup>	13.4	14.3	8.5	5.8
Medicaid buy-in <sup>c/</sup>	16.1	17.9	10.0	7.9
Illustrative Medicaid expansion <sup>d/</sup>	14.7	15.0	8.9	6.1

<sup>a/</sup> Assumes no asset test and no deductions, pregnant women are eligible through 60 days post-partum, infants are eligible for one year, medically needy programs are implemented in all states, and eligibility for unemployed parents is permitted in all states.

<sup>b/</sup> Assumes that the asset limit is increased to \$5,000, eligibility is certified for six-month periods, medically needy programs are implemented in all states, and eligibility for unemployed parents is permitted in all states.

<sup>c/</sup> Subsidized Medicaid buy-in coverage is available to all persons with incomes below 185 percent of poverty. The costs do not include premium payments.

<sup>d/</sup> The illustrative Medicaid expansion includes coverage for pregnant women and infants up to 185 percent of poverty, mandatory medically needy programs in all states, and raising the eligibility level to 100 percent of poverty and eliminating categorical requirements.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

eligibility. This is because as the eligibility level is raised, the newly eligible persons are more likely to be employed and healthier. By eliminating categorical eligibility the program would cover single adults and childless couples, many of whom are not employed and may have lower health status.

Not all persons who are eligible for Medicaid enroll. We estimate approximately 72 percent of those eligible for Medicaid are enrolled. Each option requires an assumption about how many of those newly eligible for Medicaid would enroll. We have assumed that patterns of enrollment among newly eligible persons would be similar to patterns observed in the current program: lower for persons reporting themselves to be in good or excellent health, lower for persons who are employed or have insurance from other sources, and lower as income increases. We have used a multifactor model that incorporates income, health status, presence of other insurance, and employment into the enrollment decisions of each eligible in the data base. In options that raise income eligibility levels, we estimate that 63 percent of the newly eligible would enroll in Medicaid. Enrollment rates might be influenced by new outreach efforts, but the possible impact of such activities have not been incorporated into this analysis.

Because current Medicaid eligibility levels in southern states are on average lower than in other states and incomes in these states tend to be lower than in other regions of the country, most of those who become covered under these Medicaid expansions are located in the southern region of the United States. If Medicaid income eligibility levels are increased to the poverty level while retaining current categorical criteria, about 73 percent of new enrollees would be persons living in the South, while only about 6.3 percent would be persons living in the Northeast. If eligibility were increased to the poverty level with categorical requirements eliminated, about 53 percent of new enrollees would be located in the South.

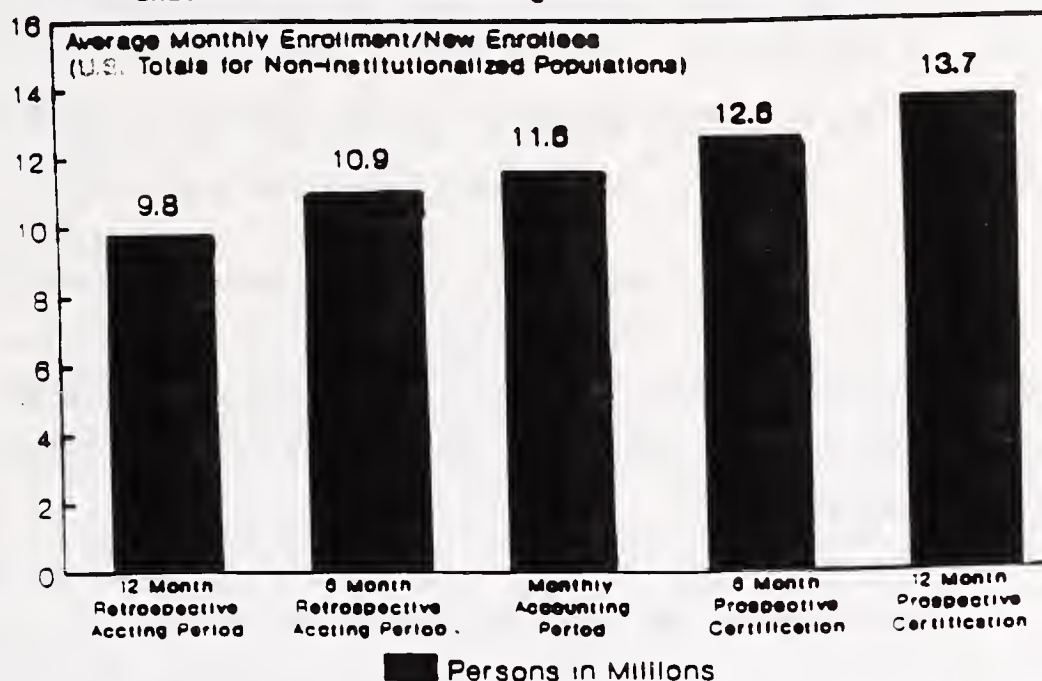
Two important policy variables that influence the number of people eligible for Medicaid expansions are the period over which income is counted (i.e., accounting period) in determining eligibility and the period of recertification for eligibility. Changing the accounting period or the recertification period results in substantially different estimates of the



number of persons eligible and enrolled in Medicaid and the costs of the program. Figure 1 presents the impact on the number of people enrolled in Medicaid if the eligibility level is increased to 100 percent of poverty but different periods are used for calculating income and recertifying eligibility.

Figure 1

**Impact of Increasing the Medicaid Eligibility Limit to the Poverty Line under Alternative Accounting Period Methods in 1989<sup>a</sup>**



<sup>a</sup>/Assumes Assets Test is increased to \$5,000 and Medicaid eligibility is decoupled from Public Assistance eligibility. Excludes medically needy income spend-down enrollees.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM)

These impacts on eligibility and enrollment of using different accounting periods and periods of eligibility recertification increase as Medicaid eligibility levels increase as the program begins to enroll an increasing number of low income workers. At eligibility levels of 40 or 50 percent of the poverty level many persons are on Medicaid all year or if they are enrolled for part of the year, they are uninsured for the remaining months of the year. In contrast, whether seasonal and part-time workers who experience fluctuations in income throughout the year would become eligible for Medicaid for the portion of the year they are unemployed depends to a large extent on which accounting period is chosen and how often enrollees are required to be recertified.

## 2. Medicare Eligibility Expansion and Reform

A major limitation of Medicare coverage is that the disabled under age 65 receiving cash assistance under SSDI do not become eligible for Medicare until two years after their initial receipt of cash benefits. This waiting period has been cited as a major barrier to access to health care for those disabled with incomes above the SSI-eligibility level (which assures Medicaid coverage) and who do not have access or cannot afford continuation coverage or non-group health insurance. Estimates of eliminating the two-year waiting period have been presented by Bye and Riley in the Social Security Bulletin.

An estimated 3 million disabled workers are covered by SSDI and are affected by the waiting period. Bye and Riley estimate the average cost per beneficiary for those who would be brought into the program would be approximately \$2,692 (in 1981 dollars). This is 45 percent higher than the average cost per beneficiary.

## 3. Requirements for Employer-based Insurance

Because approximately three-fourths of the uninsured are employed or dependents of employed persons, proposals to improve the availability of employer-based insurance have been the focus of much recent attention. Two approaches to requiring employer-based insurance were analyzed: 1) employer mandate and 2) "pay or play" approach in which employers must provide insurance or pay a tax.

### a. Employer mandate

The "Health Benefits for All Americans Act" introduced by Senators Edward Kennedy and Henry Waxman was used as the framework for our analysis of an employer mandate. This is the most recent national bill aimed at extending health insurance to all employed persons and their dependents. We examined an employer mandate alone and one coupled with Medicaid eligibility expansion and a Medicaid buy-in for those who do not become insured through work.

The employer mandate was analyzed with two benefit packages: a specified comprehensive benefit package, and a catastrophic benefit package. Under the mandate, employers would be required to provide health insurance to all employees who work at least 17.5 hours per week and to their dependents. Premium costs are shared between the employer and the employee on the basis of employee income. Employers are required to pay 80 percent of the cost of the premium for both employees and their dependents who earn more than 125 percent of the minimum wage; employers must pay the full premium for employees and dependents for those earning less than 125 percent of the minimum wage.

The number of persons affected and the costs of the employer mandate under both a specified benefit package and a catastrophic benefit package are presented in Table 5.

Table 5

## Employer Mandate with Specified Benefit Package and Catastrophic Benefit Package

	Specified Benefits	Catastrophic Benefits
Persons Covered (in millions)		
Total Affected	75.6	49.7
Worker and Dependents in Firms Required to Improve Benefit Package	25.9	0
Uninsured Under Current Policy	25.9	25.9
Insured Under Current Policy	23.8	23.8
Total Costs (in billions)		
Net Change in Employer Costs <sup>a/</sup>	24.2	7.1
Firms Not Offering Plans	7.8	(1.0)
Firms Required to Offer Plans	16.4	8.1

<sup>a/</sup> Represents the costs to employers minus a premium reduction for reduced charity care overhead charges by providers and the federal tax deduction for employer health benefits.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



A major impact of employer mandates is that they affect the health coverage of many more people than the uninsured. With the specified benefit package, the mandate would affect the health coverage of 75.6 million Americans, only one-third of whom are currently uninsured. An employer mandate with a catastrophic benefit package would affect the health coverage of 49.7 million persons.

One of the most surprising impacts of employer mandates is that while they are targeted toward employers that do not provide insurance, firms that currently do provide insurance would also be faced with significant increases in costs. Firms that do not meet the benefit requirements or the employer premium contribution required by the plan would be required to expand their plans, and firms would be required to insure part-time employees working more than 17.5 hours per week. Under the full mandate, we estimate that in firms currently offering insurance, 25.9 million persons would have their premium contribution reduced or coverage upgraded, and 6.5 million part-time workers would receive coverage.

The impact of employer mandates on coverage and employer costs are sensitive to plan design. To illustrate the sensitivity of the employer mandate to variations in program design, we analyzed eight alternative specifications of an employer mandate. The results are presented in Table 6.

Employer mandates do not cover all of the uninsured. To maximize insurance coverage, proposals often include an expansion of public insurance in addition to an employer mandate. In this analysis, we examine the interaction between employer mandates and Medicaid expansion options using the Kennedy-Waxman "Health Benefits for All Americans Act" as a model.

This plan includes an employer mandate with a specified benefit package and Medicaid expansions for the remaining uninsured. The Medicaid expansion includes: 1) extending Medicaid coverage to all persons with incomes below the poverty level without regard to categorical eligibility; and



Table 6

## Impact of Employer Mandate Under Selected Variations in Plan Design

	Workers and Dependents Who Obtain Employer Coverage (in millions)	Persons Who Remain Uninsured (in millions)	Before Tax		
			Change in Employer Costs (in billions)	Firms That Currently Offer Insurance	Firms That Currently Do Not Offer Insurance
<b>Employer Mandate</b>	49.7	6.2	\$34.0	\$12.7	\$21.3
<b>Variations in Mandate</b>					
Exempt firms with 10 or fewer employees	42.5	10.5	28.0	10.2	17.8
Apply mandate to only full-time (35+ hours) workers	41.3	9.8	29.2	9.0	20.2
Exclude temporary workers (4-month waiting period)	47.5	7.5	31.1	11.6	19.5
Exclude dependents	29.6	15.8	21.3	7.6	13.7
Prohibit spousal waivers (i.e., spouses must take coverage on own job)	49.7	6.2	35.3	(0.6)	35.9
Reduce premium sharing to 50 percent for dependents	49.7	6.2	27.3	7.6	19.7
50 percent hospital cost sharing through \$2,500	49.7	6.2	19.9	3.8	16.1
Use "pay or play" <sup>a/</sup>	27.4	20.6	29.7	10.6	19.1

<sup>a/</sup> Total employer tax payments under this option would be 8.7 billion.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

2) establishing a Medicaid buy-in for all other uninsured persons. The buy-in is subsidized for persons with incomes below 185 percent of poverty.

Table 7 presents the number of persons covered and the cost of the employer mandate with Medicaid expansion assuming full participation and less than full participation under Medicaid. The number of persons who are enrolled in Medicaid at some point in the year would be 39.2 million persons (assuming less than full participation). The employer mandate would affect 49.7 million. These numbers are not additive; some persons would receive coverage over the course of the year from both Medicaid and employer coverage.

Table 7  
Employer Mandate with Medicaid Expansion

Persons Covered	Employer Mandate	Medicaid Expansion (Less than Full Participation)	Medicaid Expansion (Full Participation)
Total <sup>a/</sup>	49.7	24.6	32.5
Total Costs			
Employer Costs	24.2		
Employers now offering insurance	7.8		
Employers required to offer insurance	16.4		
Government Costs	2.6	21.0	28.8
Federal	2.6	14.3	18.9
State	<sup>b/</sup>	6.7	9.9

<sup>a/</sup> Some persons covered by the employer mandate are also covered by Medicaid expansion during the year because of part-year eligibility.

<sup>b/</sup> State tax expenditures are not estimated.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

#### b. "Pay or play" tax approach

Our analysis of "pay or play" tax incentives is based on the plan proposed by The National Leadership Commission on Health Care (NLCHC) which would assure that all Americans have health insurance. The proposal consists of an employer tax incentive and a public health insurance fund. The plan

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uses a system of tax penalties to encourage employers to offer health insurance coverage to their workers and dependents. All persons who are not covered through their employer and are without insurance from some other source would be covered under a health insurance fund established under the plan. Medicaid would be restructured to be a long-term care program and persons formerly covered under Medicaid would be covered under the fund.

All of the currently uninsured would be covered under this plan, about one-half by an employer plan and one-half under the fund. Overall the source of insurance coverage would change for 105.2 million persons, about 46 percent of whom would become covered under employer-sponsored health insurance. Over 70 percent of the 105.2 million persons who are affected by the plan are currently insured (Table 8). The plan would result in a reduction in costs for employers who now sponsor insurance of \$11.2 billion while increasing employer costs for those who do not now offer coverage by \$25.3 billion.

Our analysis indicates that the employer and employee tax revenue will not provide the financing needed to support the fund. Total expenditures under the fund would be about \$91.6 billion. The fund would obtain about \$11.8 billion in revenues from the tax penalty payments by employers who fail to offer insurance. Individuals participating in the fund would pay a tax of 2.1 percent on adjusted gross income, bringing in revenues of \$6.0 billion. Finally, \$39.0 billion in funds that would have been used to finance benefits under the Medicaid program would be transferred to the fund.

The plan would require an additional \$34.7 billion in revenue to finance expenditures under the fund. About \$7.9 billion represents the increase in Medicaid payment rates to market rates under the fund. The remaining \$26.8 billion shortfall is larger than the funds raised from both the tax penalty and the individual income tax. This occurs for three reasons:

Table 8

Persons Potentially Affected by the Pay or Play Proposal  
by Source of Coverage Under Current Policy  
(in millions)

	Persons Potentially Affected by Pay or Play Plan	Persons Who Become Covered Under Employer Plan	Persons Who Become Covered Under Fund
Uninsured under current policy	31.5	16.1	15.4
Insured by Medicaid under current policy <sup>a/</sup>	23.3	3.3	20.0
Insured through non-group insurance under current policy	21.0	13.5	7.5
Workers and dependents in employer plans shifted to fund <sup>b/</sup>	5.4	--	5.4
Working spouses and dependent children shifted out of existing employer plans <sup>c/</sup>	24.0	16.0	8.0
Total	105.2	48.9	56.3

<sup>a/</sup> Non-institutionalized Medicaid participants are transferred to the fund.

<sup>b/</sup> Employees are permitted to terminate their plans and cover individuals under the fund by paying the tax.

<sup>c/</sup> Working dependent spouses who are covered by employer plans now become covered through their own employer, some of whom will cover these workers under the fund by paying the tax. Dependent children are also allocated across the patient's plan in cases where both spouses are working.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



- Coverage by the fund of non-working uninsured requires additional sources of funds. There are no tax payments by employers to help cover this population. This coverage costs an additional \$19.2 billion.
- The tax rate is set at the average premium. Some employers confront higher than average premiums because of the demographic and health status characteristics of their workforce. These firms might choose to pay the tax and transfer their workers into the fund rather than provide insurance.
- The tax as a percent of payroll is often less than the actuarial value of benefits. When the tax is collected as a percentage of salary and wages, the tax that must be paid for lower income workers is less than the actuarial value of benefits. This shortfall can be reduced by using a lower wage base and higher tax rate. It should be kept in mind, however, that the higher the cost relative to salary, the greater the pressure on employers to reduce their employment of lower income workers or restrict wage increases. We have estimated the shortfall for employed persons due to these factors at \$7.6 billion.

#### 4. Comparison of Alternative Proposals

Five of the options analyzed are compared along three critical dimensions: 1) impact on the total number of uninsured; 2) impact on health care expenditures and sources of payment; and 3) target efficiency of the proposals.

##### a. Impact on the total number of uninsured

The options analyzed vary to the extent they cover the currently uninsured. Some options, such as selected Medicaid expansion options are designed to cover high priority groups among the uninsured (e.g., pregnant women and children). Other options, such as the pay or play approach, are designed to cover all or nearly all of the uninsured. The number of persons who remain uninsured under each option is shown in Table 9.

Table 9

**Impact of Selected Health Insurance Expansion  
Proposals on the Number of Uninsured Persons**

	<b>Number Uninsured (in millions)</b>
Current Policy	31.8
Illustrative Medicaid Expansion	24.6
Medicaid Buy-in Proposal	21.3
Employer Mandate with Specified Benefits	6.2
Employer Mandate with Medicaid Expansion (less the full participation)	2.7
Employer Mandate Medicaid Expansion (full participation)	0.0
Pay or Play Approach	0.0

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

**b. Impact on health care expenditures and sources of payment**

Total new health care expenditures under each of the plans range from \$2.4 billion under the Medicaid buy-in proposal to \$11.3 billion under the universal coverage proposals. Extending insurance coverage to all the uninsured would result in total induced demand of \$11.3 billion under the universal coverage proposals. However, under an employer mandate plus Medicaid expansion, new spending by employers would be \$26.4 billion and new spending by government would be \$17.7 billion. The amount in excess of the \$11.3 billion in new services represents the refinancing of services currently being provided to the uninsured and those insured whose coverage is changed. The large amount of refinancing of current services that occurs under these options heightens the debate over which payor should bear the cost of extending health insurance to the uninsured.

**c. Target efficiency of the proposals**

Target efficiency was defined in two ways: 1) the extent to which they cover the uninsured and minimize their impact on the insured; and 2) the extent to which government expenditures are targeted toward the uninsured. In general, the employer mandate options are more target efficient than the

**Lewin/ICF**

Medicaid expansion options at covering the uninsured. Further, the employer mandate is more effective at directing government expenditures to the uninsured than are any of the other proposals (Table 10). Employer mandates, it should be noted, provide insurance to a greater proportion of the higher income uninsured.

### 5. Administrative Feasibility

Administrative feasibility and administrative burden are major considerations in reviewing options. A large administrative burden increases program costs and may make it difficult to successfully achieve the goals of the program. Administrative feasibility is examined along three dimensions: 1) the extent they require new administrative structures; 2) the extent they entail coordination of benefits; and 3) the extent they involve transitions in enrollment.

Employer mandates and the pay or play approach entail the greatest administrative burden compared to Medicaid options. However, these options also cover the most people. The employer mandate with Medicaid expansion and the pay or play approach would involve new administrative structures, efforts to coordinate benefits, and a large number of transitions in coverage, due to part-year enrollment. The employer mandate with Medicaid expansions and the pay or play approach would result in 26.6 million and 23.4 million transitions per year, respectively, while the illustrative Medicaid expansion package and the Medicaid buy-in would result in 6.5 million and 8.2 million transitions per year, respectively.

Table 10

## Target Effectiveness of Government Expenditures Under Alternative Policies

	Persons Whose Source of Coverage Is Modified (in millions)	Affected Persons Who Were Uninsured Under Current Law (in millions)	Percent of Affected Persons Who Were Uninsured	Proportion of Government Expenditures Targeted to the Uninsured
Illustrative Medicaid Expansion <sup>a/</sup>	17.1	6.9	40.3%	48.8
Medicaid Buy-In <sup>b/</sup>	20.7	10.2	49.3	57.6
Employer Mandate with Specified Benefits	50.4	25.3	50.1	61.4
Employer Mandate with Medicaid Expansion <sup>c/</sup>	74.7	31.5	42.2	50.1
Pay or Play	105.2	31.5	29.9	33.0

<sup>a/</sup> Total family health expenditures include premium payments by family members and out-of-pocket spending for personal health care.

<sup>b/</sup> This Medicaid policy extends coverage to persons with monthly income below the poverty level (185 percent for pregnant women and infants), decouples from categorical eligibility, sets the asset eligibility limit at \$5,000, and establishes a medically needy program in all states.

<sup>c/</sup> Assumes all eligible persons participate in the Medicaid program during months where uninsured.

Lewin/ICF

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

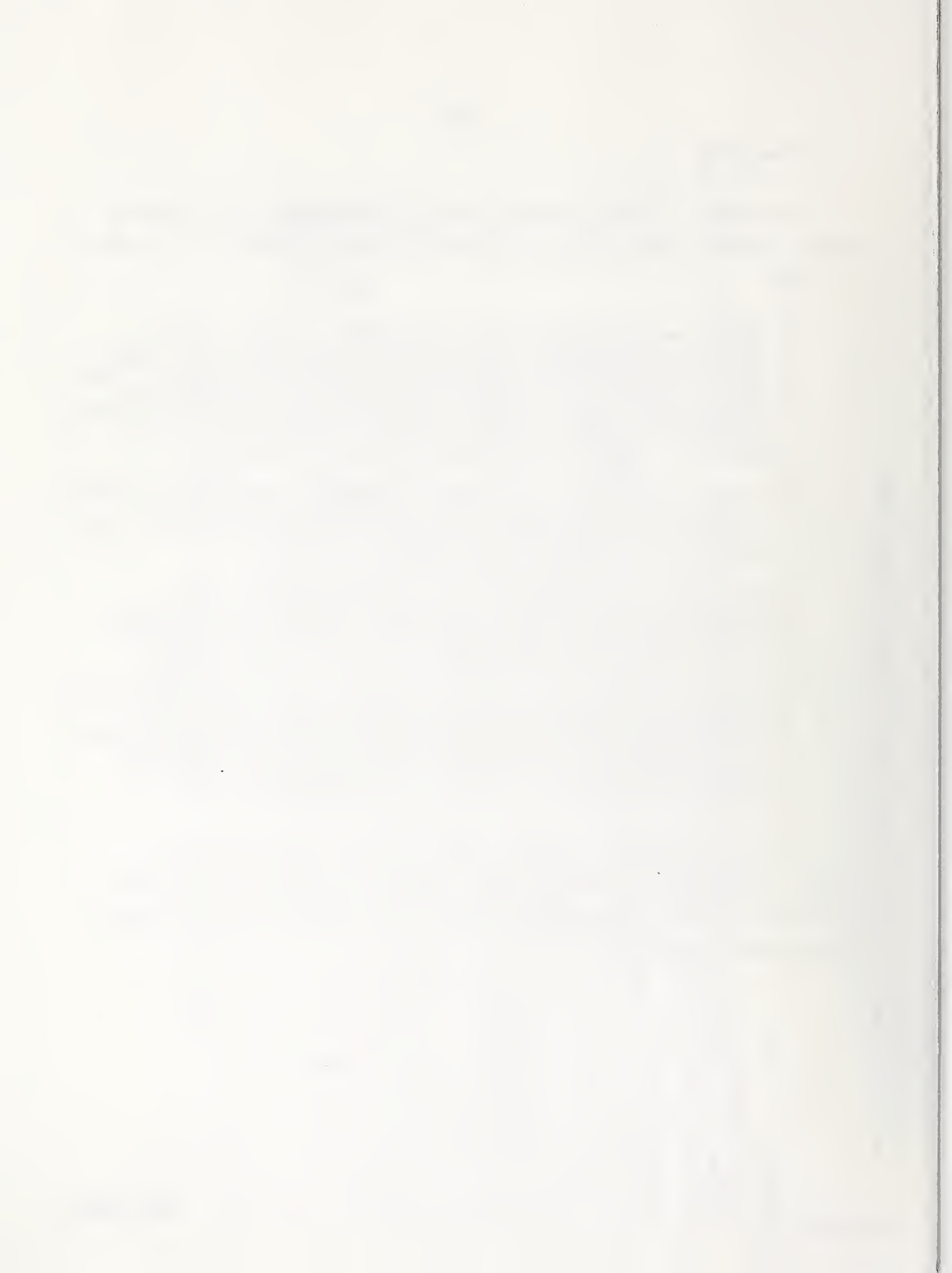


## 6. Conclusion

The results of this analysis of alternative approaches for extending health insurance to the uninsured confirm the issues highlighted at the end of Part One.

- Options are not easily targeted only to the uninsured. Those choosing among them must balance concerns about target efficiency against the proportion of the uninsured who receive coverage. Those proposals which cover the greatest number of the uninsured also affect large numbers of insured persons. These proposals vary in the number of uninsured covered and the extent to which they create shifts in coverage among those who are currently insured.
- Options to expand coverage involve substantial refinancing of current health care spending. The extent to which the burden of this refinancing is borne more by government or employers depends on the option and financing strategy adopted.
- Proposals vary to the extent they target low income persons. Medicaid expansion options are targeted to low income populations. Employer mandates, while covering a large number of low income persons, also affect a large cohort of higher income persons.
- Proposals also vary in the administrative demands they impose and who would have to address them. Assuring universal and continuing coverage and coordination of benefits in a system that relies on both employer-based coverage and public coverage as well as effective transition between them will impose substantial administrative demands.

Whether considered in terms of the number of uninsured covered, refinancing of care, or administrative complexity, choosing among options requires decisions to be made about the relative priority of important but conflicting objectives.



**PART ONE:**

**GAPS IN COVERAGE AND SOURCES OF CARE FOR THE UNINSURED,  
UNDERINSURED, AND PERSONS WITH HIGH-EXPENSE ILLNESS**





PART ONE: GAPS IN COVERAGE AND SOURCES OF CARE FOR THE  
UNINSURED, UNDERINSURED, AND PERSONS WITH HIGH-EXPENSE ILLNESS

INTRODUCTION

The rapid growth in the number of persons with AIDS has heightened awareness of the gaps in financing health care for the uninsured, underinsured, and persons with high-expense illness. The 1988 Presidential AIDS Commission highlighted problems in access to health care for persons with HIV infection, and also noted that these problems were reflections of problems for the uninsured and underinsured in general. In Part One of this report, we describe the uninsured and underinsured populations, examine how the sources of insurance influence the number of uninsured, identify financing and delivery systems of health care for the uninsured, discuss the gaps in their access to care, and assess the consequences of the current financing system for the uninsured, providers who serve them, and public and private programs that help finance their care.

Concern about the problems of the uninsured has received a great deal of recent attention at the federal, state, and local level as well as in the private sector. Increasingly proposals are being advanced to address the shortfalls in the health care financing system and to extend coverage to the many Americans without health insurance.

As these proposals are debated, discussions will focus on the nature and extent of the access problems of the uninsured and underinsured. These problems can be categorized along four dimensions:

- **Sufficiency of Care:** Are the uninsured receiving sufficient care to meet their needs and are there particular populations that especially lack access?
- **Efficiency of Care:** Is the care being provided to the uninsured timely and provided in a cost-efficient manner?
- **Equity of Financial Burden:** Is the financing of care to the uninsured appropriately distributed across providers and payors?

- **Stability of the System:** Can the current systems of financing and delivering care for the uninsured be sustained over time.

This synthesis examines how well the current health care system is performing along these dimensions. To accomplish this, it examines the system first from the perspective of the individual or family without coverage, providing information on the number of uninsured, their characteristics, and the consequences of lacking adequate health insurance. The synthesis then analyzes these issues from the perspective of the health care financing system as a whole. It reviews how health care is currently financed for the insured and uninsured, examines why the uninsured lack coverage, and describes recent efforts to expand insurance coverage to the currently uninsured.

Compiling a picture of the uninsured and underinsured requires drawing from a range of data sources. Among the surveys available to examine the number and characteristics of uninsured and underinsured and their experience in the health care system are: the Robert Wood Johnson Foundation access surveys; federally funded surveys conducted by the National Center for Health Statistics (National Health Interview Survey conducted annually); National Medical Care Utilization and Expenditure Survey, conducted in 1980 and cosponsored by the Health Care Financing Administration), National Center for Health Services Research (National Medical Care Expenditure Survey, conducted in 1977; National Medical Expenditure Survey, conducted in 1987 with data currently being compiled) and Bureau of the Census (Current Population Survey, annual; Survey of Income and Program Participation, ongoing panel).

While each of these surveys has information on health insurance coverage, the surveys vary with respect to the information they provide on the characteristics, income, employment and health care use of the population surveyed, and each covers different time periods. The analysis conducted for this synthesis relies principally on the Current Population Survey (CPS) for 1988 and the National Medical Care Utilization and Expenditure Survey of 1980 (NMCUES). We have adjusted the NMCUES data to reflect hospital and physician utilization changes and health care cost increases between 1980 and 1988. Other surveys are also cited as appropriate.

The synthesis is organized into eight sections:

- The size of the uninsured population.
- Characteristics of the uninsured population.
- The size and characteristics of the underinsured population.
- Consequences of uninsurance and underinsurance.
- Financing of health care for the insured and uninsured.
- Why the uninsured and underinsured lack coverage.
- Public and private efforts to expand insurance.
- Conclusion.

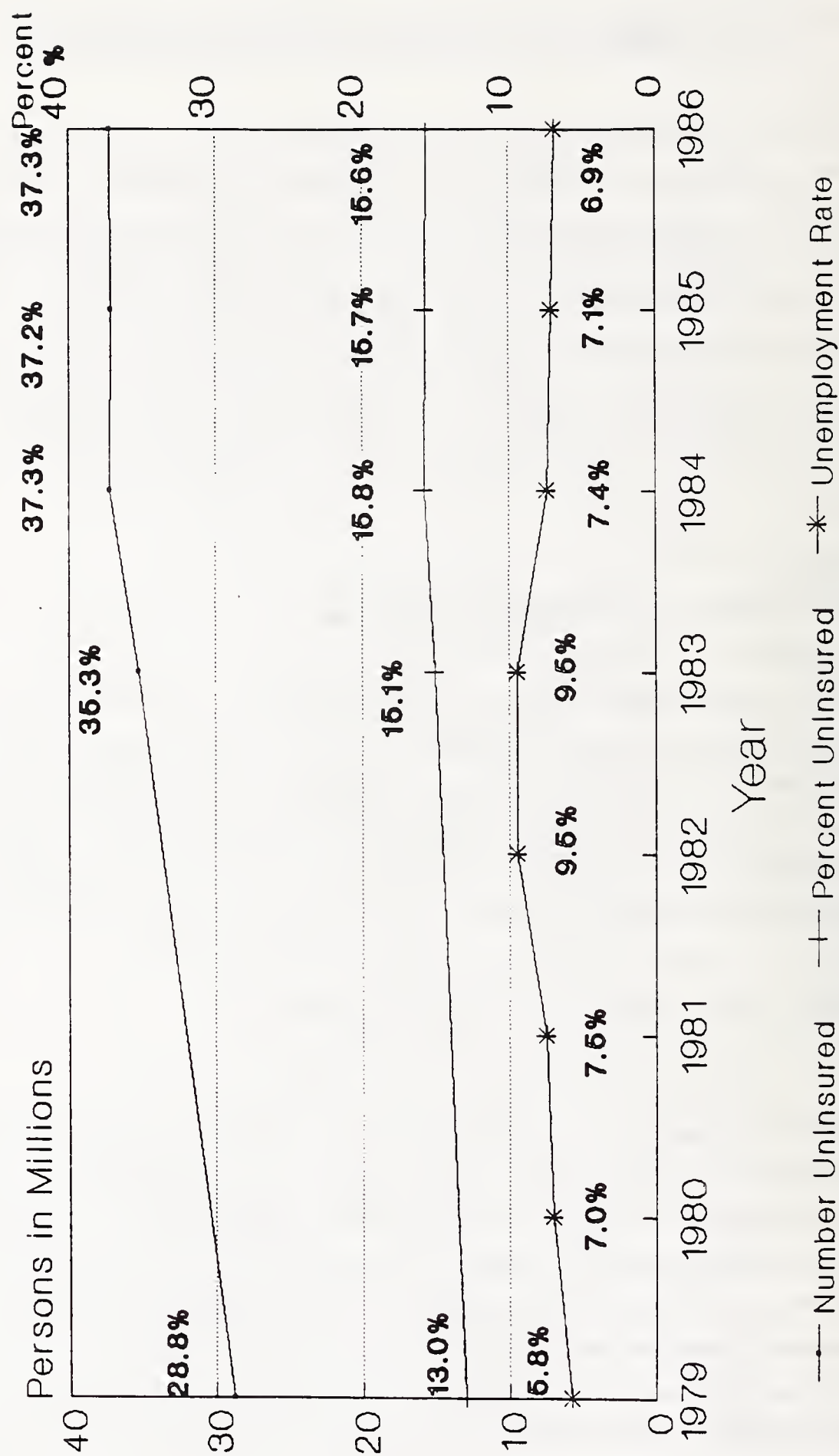
#### A. THE SIZE OF THE UNINSURED POPULATION

An estimated 31.8 million Americans, or 13.2 percent of the United States population, have no public or private health insurance. The number of persons without health insurance has increased since 1980, with substantial growth occurring between 1979 and 1984. Since 1984, the number has remained roughly constant. This section presents the trends in the number of uninsured and discusses recent revised estimates of the number of uninsured persons.

##### 1. Trends in the Uninsured Population

The number of uninsured increased substantially from 1980 to 1984, and has remained constant since 1984. The number of uninsured was estimated in the CPS at 28.8 million in 1979, and 37.3 million in 1984 (Figure 1), a 30 percent increase. Uninsured persons as a percentage of the population increased from about 13.0 percent in 1980 to about 15.8 percent by 1984. From 1984 to 1986, however, the number of persons reported to be without health insurance remained roughly constant at about 37.3 million. Changes in the CPS questionnaire have resulted in a lowering of the estimate of the number of uninsured, with the number now estimated at between 31 to 34 million.

# FIGURE 1 TRENDS IN THE UNINSURED POPULATION



Source: Congressional Research Service,  
Analysis of Current Population Survey  
data for selected years.



The increase in the percentage of the population lacking health insurance appears to have been associated with the economic recession which occurred during the early 1980s. The increase in unemployment from about 5.8 percent in 1979 to about 9.5 percent in 1983 (Figure 1), and the resulting loss of employment-based insurance, is thought to be the primary reason for the increase in the number of uninsured by about 6.5 million persons during the 1979 through 1983 period.

The number of uninsured persons did not decline, however, as the unemployment rates dropped during the recovery from the recession. Although the unemployment rate declined from about 9.5 percent in 1983 to about 6.9 percent in 1986, the number of persons reported to be without health insurance has remained roughly constant during the 1984 through 1986 period. The reasons the number of uninsured has remained up despite the decline in the unemployment rate are unclear. One likely explanation however, is that the increase in employment since the recession has been largely concentrated among the service industries where the percentage of employers offering health insurance is relatively low. For example, between 1980 and 1986 the annual average rate of increase in employment in service industries was 4.3 percent. Manufacturing, however, an industry in which employers are more likely to offer health insurance, reported an average rate of decline in employment of 1.1 percent (US Department of Commerce, Bureau of Census, 1989). Other possible explanations include the decline in the Medicaid-eligible populations, the increase in the number of Americans with incomes below the poverty level, and changes in employer health plans which require greater employee cost sharing.

## 2. Revised Estimates of the Number of Uninsured Persons

As noted above, the most recent estimate of the number of uninsured is 31.8 million persons as of 1987.<sup>1</sup> This estimate, however, is substantially different from the estimate of 37.3 million uninsured persons reported in the CPS for 1986. Most of the difference between the two estimates is attributed to changes in questions asked in the 1988 CPS concerning the insurance coverage of children in the household.

In the March CPS survey for 1988, the Bureau of the Census substantially revised its health insurance questionnaire to improve the accuracy of health insurance coverage data. The survey was revised to gather additional information on the sources of health insurance coverage for children from Medicaid and from other sources outside the family (e.g., divorced parents). Other health insurance coverage questions were also revised to improve the reporting of private health insurance coverage and coverage of dependents under a spouse or parent's plan. To illustrate the impact of this change, the 1988 CPS estimates 8.9 million uninsured children compared with the 1987 CPS estimate of 12.2 million. This difference in the number of uninsured children represents about 60 percent of the difference in the total number of uninsured persons.

Preliminary results from the National Medical Expenditure Survey (NMES) for early 1987 place the number of uninsured persons at 37 million. This larger estimate from NMES may be consistent with the revised CPS estimate of 31.8 million persons since fewer persons go without coverage for an entire year than for a few months (Short, Monheit, Beauregard, 1989).

The consensus among the research community is that the change in the estimated number of persons without insurance should not be interpreted as a

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<sup>1</sup> Another analysis of the March 1988 CPS places the number at 31.1 million persons compared to 31.8 million. The variation in these two estimates reflects different edits to the data. For a further discussion of this analysis see Moyer, Health Affairs, Summer 1989.

reduction in the actual number of uninsured persons during this period. It is generally believed that the apparent decline in the number of uninsured persons reported in the CPS for these two years is nearly entirely attributed to the change in the design of the CPS questionnaire rather than an actual decline in the number of persons without insurance. The lower estimate is believed by many researchers to be more accurate than the widely publicized 1987 CPS estimate of 37.3 million uninsured persons. However, it should be noted that some researchers are concerned that the March 1988 CPS may now underestimate the number of uninsured persons due to certain ambiguities in the new CPS questionnaire (Rich, July 1, 1989). Although there is a growing view that this may be the case, the 1988 CPS preliminary release is the most current and appropriate data available for analyzing the number and characteristics of the uninsured.

#### B. CHARACTERISTICS OF THE UNINSURED POPULATIONS

The 31.8 million uninsured persons are a complex mix of 1) persons who lack access to health insurance; 2) persons who cannot afford coverage that is available to them; 3) persons who have access to insurance and the financial resources to purchase it but choose not to take the coverage; and 4) persons who are unaware of the various sources of insurance that may be available to them. Many low wage workers and their dependents are without insurance because their employer does not offer it, they are ineligible for Medicaid, and/or they cannot afford non-group coverage. However, the uninsured also include individuals with annual incomes of \$50,000 or more who presumably could afford insurance. They may choose to remain uninsured and pay for care out-of-pocket or they may be excluded from coverage due to preexisting health conditions. Similarly, some of the uninsured are persons who are eligible for Medicaid but do not enroll because they lack information about the program. We discuss reasons for lack of insurance further in Sections D and E below.

Individuals who are likely to be uninsured are on average: younger than the general population, in lower income groups, unemployed, and report



themselves to be in poorer health than the general population. The uninsured are also disproportionately hispanic and nonwhite. However, because some of these segments of the population are small, most of the uninsured are: adults, employed or dependents of employees, in good or excellent health, and white. Nearly 40 percent have family incomes over \$20,000 and over one-fifth have incomes over \$30,000. Thus, in reviewing the characteristics of the uninsured, one must be careful to distinguish between the factors that increase the probability of not having insurance, and the actual distribution of the uninsured among groups within the population.

### 1. Demographic Characteristics of the Uninsured

A substantial portion of the uninsured are children. About 28 percent of the uninsured are under the age of 18, with 9.4 percent under age 6 (Table 1). While 13.2 percent of the population is uninsured, about 13.6 percent of all children under the age of 6 and about 14.3 percent of children age 6 through 17 lacked insurance.

The percentage of persons lacking health insurance is greatest among adults age 18 through 24. For persons age 18 through 21, 20.9 percent are uninsured. Among persons age 22 through 24, 26.6 percent are uninsured. In the population age 25 and older, the percentage of persons without health insurance declines with age. Because of the availability of Medicare coverage, fewer than 1 percent of the population age 65 and older is without health insurance.

Men are more likely to be uninsured than women, with 14.4 percent of all men uninsured compared with 12 percent of all women. The lower incidence of uninsurance among women may be attributed to Medicaid which is targeted toward women with dependent children as well as to the larger share of women among the elderly who are almost universally covered by Medicare.

A disproportionate share of nonwhites and hispanics are uninsured. About 31.4 percent of all hispanics report that they do not have health



Table 1

## Uninsured Persons by Age, Sex, and Race/Ethnicity, 1987

	Number of Uninsured Persons (in millions)	Percentage of All Uninsured	Uninsured as Percentage of Persons in Group
Age of Individual			
Less than 6	3.0	9.4%	13.6%
Age 6-17	5.9	18.6	14.3
Age 18-21	3.0	9.4	20.9
Age 22-24	3.1	9.8	26.6
Age 25-34	7.2	22.7	16.8
Age 35-44	4.2	13.1	12.0
Age 45-54	2.7	8.5	11.4
Age 55-64	2.4	7.6	11.2
Age 65+	0.3	0.8	0.9
Sex of Individual			
Male	16.9	53.2	14.4
Female	14.9	46.8	12.0
Race/Ethnicity			
White	24.7	77.5	12.1
Non-white	7.2	22.5	19.2
Hispanic	6.1	19.2	31.4
All Persons	31.8	100.0	13.2

Source: Preliminary estimates from the March 1988 Current Population Survey data, July 1, 1989. Subject to revision.

insurance (Table 1). About 19 percent of all nonwhites lack health insurance while only about 12 percent of the white population is uninsured. Further, preliminary NMES results indicate that one-half of the black and hispanic populations are privately insured, compared to nearly 81 percent of the white population. Public programs, while providing coverage to one-fourth of the blacks and about one-fifth of hispanics, do not close the gap in private coverage (Short, Monheit, Beauregard, 1989).

## 2. Income Characteristics of the Uninsured

Most of the uninsured are low income. Nearly one-half of the uninsured have incomes below 150 percent of the poverty line (\$18,150 for a family of four). Among persons in families with total family income of less than \$5,000, 29.5 percent were uninsured (Table 2). The chance of being uninsured is greatest for low-income families and declines as income increases. Thus, more than one-quarter of the population below poverty is without coverage compared to only 5.6 percent of persons with incomes greater than 300 percent of poverty (\$36,300 for a family of four).

While many of the uninsured are poor, 12.2 million (38 percent) of the uninsured have incomes greater than 200 percent of poverty. While at risk for catastrophic expenses beyond their ability to pay, this group is likely to be able to afford routine primary and preventive care. The reasons why persons in higher income groups lack insurance are unclear. Among those for whom employer-provided insurance was unavailable, some may have decided not to purchase non-group insurance because they have sufficient income and assets to accept the risk of financing their own health care. It is also possible however, that some of these individuals are in poor or fair health, or have chronic conditions, and are excluded from obtaining coverage by preexisting condition restrictions in insurance policies.

Table 2

## Uninsured Persons by Family Income and Income as a Percent of Poverty, 1987

	Number of Uninsured Persons (in millions)	Percentage of All Uninsured	Uninsured as a Percentage of Persons in Income Group
<u>Family Income in 1987</u>			
Less than \$5,000	4.4	13.9%	29.5%
\$5,000 - 9,999	5.3	16.6	23.6
\$10,000-14,999	5.3	16.9	24.0
\$15,000-19,999	4.3	13.6	19.3
\$20,000-29,999	5.1	15.9	12.4
\$30,000-39,999	2.9	9.2	7.9
\$40,000-49,999	1.9	5.8	6.7
\$50,000 or more	2.6	8.1	4.9
<u>Income as Percent of Poverty</u>			
Below Poverty	9.5	30.0	29.1
100-149%	5.7	17.8	25.8
150-199%	4.4	13.8	19.4
200-299%	5.6	17.6	12.2
300 or more	6.6	20.9	5.6
All Persons	31.8	100.0%	13.2%

Source: Preliminary estimates from the March 1988 Current Population Survey data, July 1, 1989. Subject to revision.

### 3. Labor Force Status of the Uninsured

Almost two-thirds (63 percent) of all uninsured adults are employed. Of these, two-thirds are employed full-time, while one-third are employed part-time. The large proportion of uninsured adults who are employed has led to increased interest in expanding employer-based insurance to reduce the number of uninsured. Ten percent of uninsured adults are unemployed and looking for work while 26 percent (6 million) are not in the labor force (i.e., persons who are neither working nor unemployed and looking for work) (Figure 2).

Of the adults who are not in the labor force, one-half are engaged in housekeeping, 4 percent are in school, and about one-third reported they are unable to work or are retired. This latter group, those unable to work or retired, represent one-tenth of the uninsured. They are likely to find non-group insurance unavailable or priced substantially higher than they can afford.

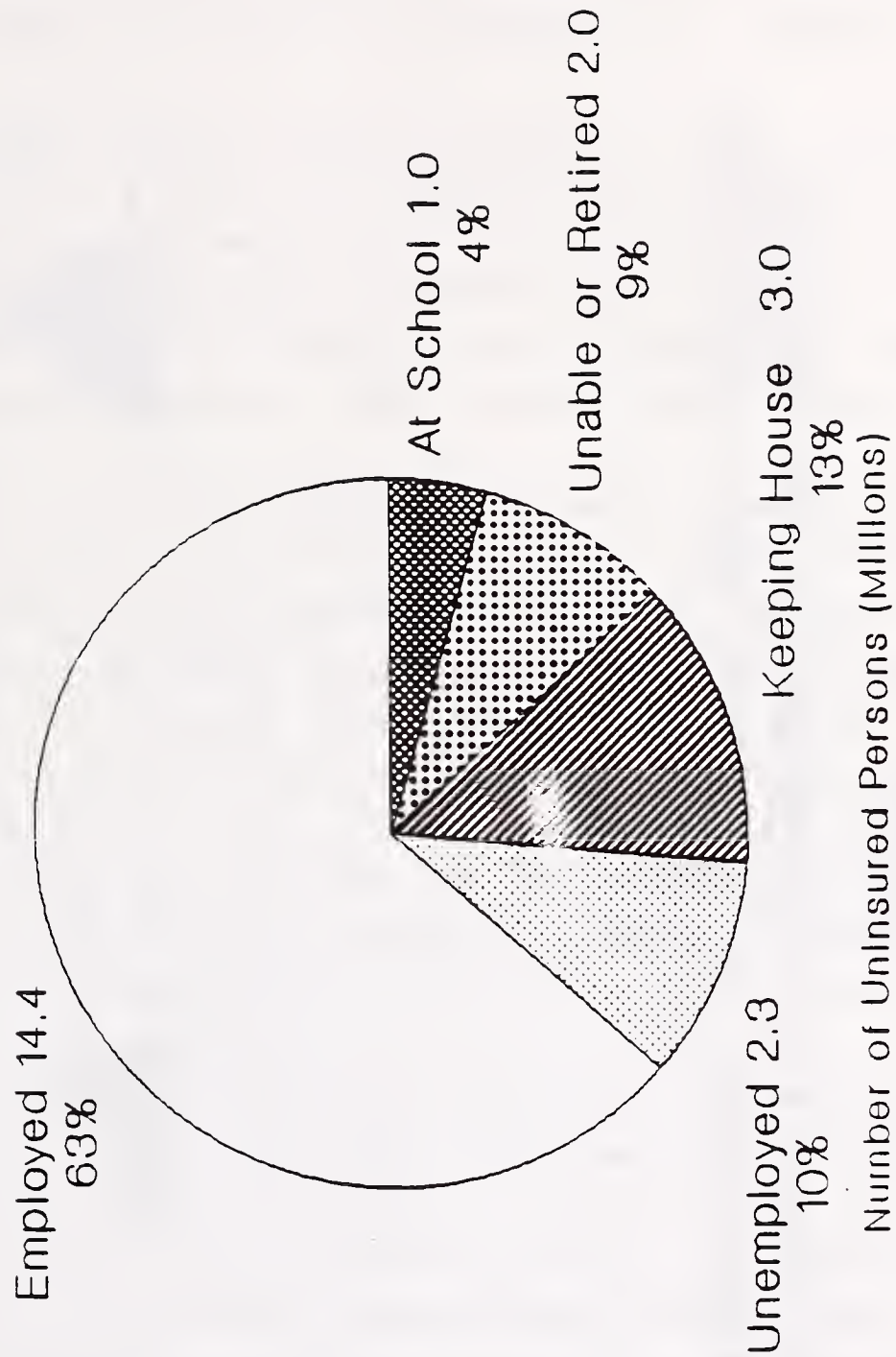
### 4. Health Status of the Uninsured

One of the possible consequences of being uninsured is that individuals will have poorer health status because they do not have access to care at a time they need it. On average, the uninsured report themselves in better health status than the insured. Since the uninsured are younger than the insured, we have adjusted the NMCUES data for differences in the age composition of the insured and uninsured populations to better isolate the differences in health status associated with the lack of health insurance.

On an age-adjusted basis, we found the uninsured appear to be in poorer health than the insured (Figure 3). As shown, on an age-adjusted basis, about 4 percent of the uninsured indicated that they were in "poor" health compared to about 2.5 percent for the insured population. About 11 percent of the uninsured reported they were in "fair" health compared to



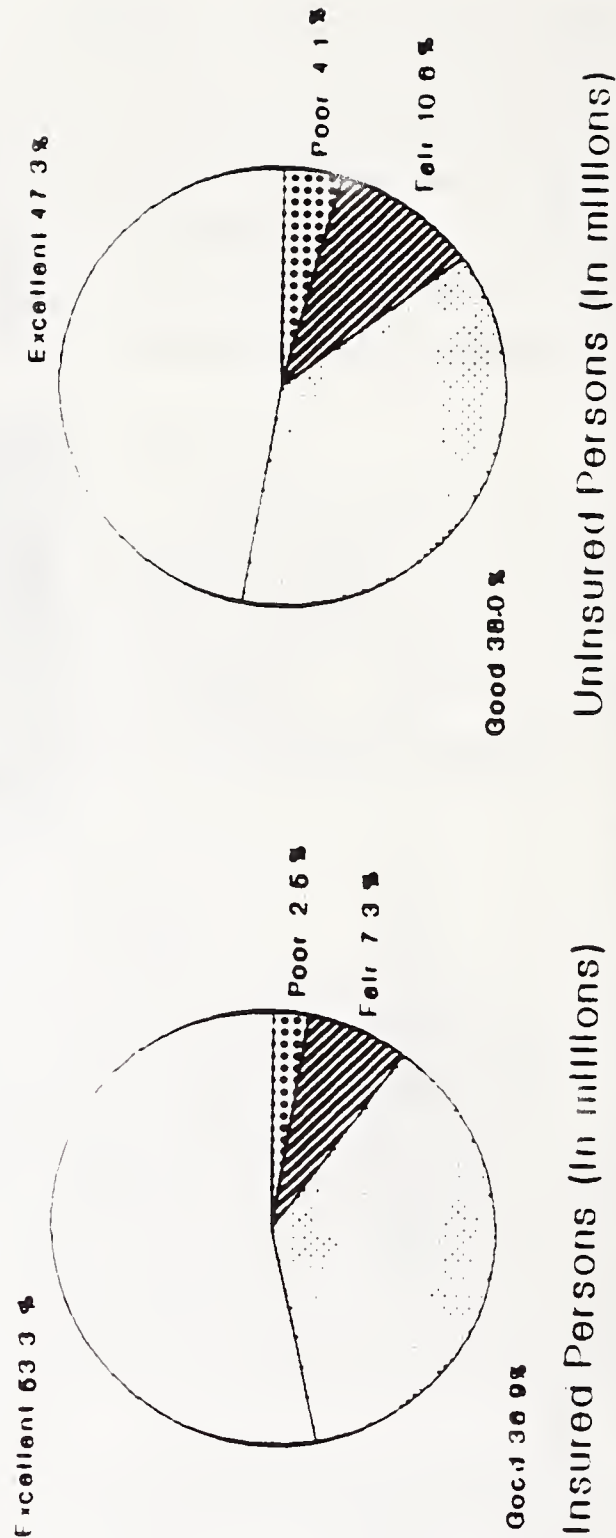
**FIGURE 2**  
**UNINSURED PERSONS AGE 18-64 BY LABOR**  
**FORCE STATUS (22.6 MILLION PERSONS)**



SOURCE: Preliminary estimates from the March 1989 Current Population Survey (CPS) Data.

**FIGURE 3**

**AGE ADJUSTED DISTRIBUTION OF INSURED  
AND UNINSURED PERSONS BY SELF-REPORTED  
HEALTH STATUS**



SOURCE: Lewin/ICF Analysis of the 1980  
National Medical Care Utilization and  
Expenditures Survey (NMCIUS)

7 percent of the insured population. About 53 percent of the insured reported "excellent" health compared with only about 47 percent of the uninsured.

The percentage of persons reporting themselves to be in poor health was greater among uninsured persons than among the insured at all age levels (Table 3). For example, among persons age 55 through 64, the percentage of persons in poor health was 16 percent for uninsured persons compared with about 10 percent among those with insurance. Among both insured and uninsured persons, the percentage reporting poor health status increases with age.

The uninsured are generally more likely to report having a health condition limiting their daily activities than are insured persons (Table 3). On an age-adjusted basis, about 6.4 percent of the uninsured reported a health-related limitation on daily activities compared with 5.7 percent among those with insurance. In particular, uninsured persons age 45 or older were generally more likely to report limitations in activity than were the insured. However, among some age groups, such as children under age 18, the percentage of persons with limitations in activity was lower among the uninsured than among those with insurance. This may be because children with limitations in activity may be eligible for Medicaid as a result of their health status.

The role of health insurance in explaining these differences in health status is unclear. A lack of insurance may cause persons to forgo needed care, thereby diminishing health status. In contrast, the causal relationship may go the other way. Poor health status may be the reason an individual is uninsured. For example, persons in poor health may have lost their jobs and their employment-based insurance and may not have sufficient income to purchase continuation coverage or non-group coverage and may be ineligible for Medicaid or Medicare. This may be a prominent factor among older uninsured populations and among persons with chronic disabling conditions or AIDS.

Table 3  
Health Status Indicators for Insured and Uninsured Persons

	<u>Percentage Reporting Themselves To Be in Poor Health</u>		<u>Percentage Reporting Condition Causing Limitation in Activity<sup>a/</sup></u>	
	Insured	Uninsured	Insured	Uninsured
Under 18	0.3%	0.4%	3.9%	2.9%
18-24	0.9	1.7	4.6	4.7
25-34	1.6	2.9	3.2	5.1
35-44	2.8	3.2	4.3	2.3
45-54	4.9	8.9	7.3	13.9
55-64	9.9%	16.2%	16.9%	18.2%
Age Adjusted Percent for Persons Under Age 65	2.5%	4.1%	5.7%	6.4%

<sup>a/</sup> Includes persons who 1) cannot perform usual activity, 2) are limited in amount and kind of usual activity, or 3) are limited in outside activities.

Source: Lewin/ICF analysis of the 1980 National Medical Care Utilization and Expenditure Survey.



Persons with AIDS are of particular concern in this analysis given the evidence of problems of financing care for AIDS patients. While the available data on the insurance status of persons with AIDS is limited, a number of studies have estimated that more than 30 percent of persons with AIDS including children are Medicaid recipients (US DHHS, (ASPE), 1988; Kizer, et al., 1988).

Because of the rapidly debilitating course of the disease, it is likely that persons will incur very high health care expenses soon after diagnosis of AIDS. Those who are employed often leave their jobs, unable to continue to work, thereby losing employment-based insurance. Many spend down to become eligible for health coverage through Medicaid. An analysis of California Medi-Cal (Medicaid) eligibility records found that for those with private insurance who were not eligible for Medi-Cal at the time of diagnosis of AIDS, the average time from diagnosis to Medi-Cal eligibility was 6.7 months (Kizer, et al., 1988).

Other studies have shown that a similar proportion of the chronically disabled -- persons with conditions that generate constant high health care expenses that persist for long periods of time -- are Medicaid recipients; another 30 percent are estimated to benefit from Medicare coverage, and estimates of uninsurance for this population range from 10.5 to 18 percent (US DHHS (ASPE), 1988).

Persons with activity-limiting disabilities are more likely to be uninsured. The 1984 Survey of Income and Program Participation (SIPP) found that there were 17.9 million working-age persons with an activity-limiting disability, 18 percent of whom were uninsured. This is one-third higher than the rate of uninsurance in the overall U.S. population.

Over one-half of those with activity-limiting disabilities were unemployed. Of those, only 40 percent had private health insurance. Thirty-nine percent had some other health insurance, and almost 21 percent reported having no insurance (Griss, 1988). Of those who were employed, approximately

78 percent relied on private insurance alone, another 8 percent had some combination of private/public/other coverage, and 14 percent had no insurance at all. This suggests the difficulty persons with disabling conditions and high health expenses have affording, obtaining, and retaining private health insurance.

The low-income disabled (disabled persons with incomes below the federal poverty line) face particular difficulty in obtaining health insurance. While Medicaid and Medicare both include a number of provisions designed to improve access to persons with disabilities, these programs utilize eligibility criteria which restrict the ability of low-income disabled persons to enroll (Rymer and Burwell, 1989). For instance, the link between Medicaid and SSI eligibility limits the number of low-income disabled persons who may receive Medicaid because in most states the SSI income eligibility level is below the federal poverty level.

#### 5. Insured Status of Other Family Members

Many of the uninsured live in families where other family members are insured. Among uninsured persons living in families, about one-third were in a family where at least one other family member had insurance coverage (Table 4). This may occur for several reasons. Employer-based insurance may only be affordable for the employee but not dependents, families may obtain non-group coverage for only some family members, and children may be insured by a relative not living in the household.

These data suggest that the number of uninsured could be substantially reduced by expanding the number of persons who accept family coverage under their employer or non-group plan. For example, 3.4 million uninsured persons were in a family where one or more other family members had employer-based insurance. Of these 2.6 million uninsured persons were in families where either the family head or the spouse of the family head had employer coverage on their job (Figure 4). About one-fourth of these persons were uninsured spouses of workers who had employer coverage. Over one-half were children under the age of 18 of the working family head or spouse. These

Table 4

Uninsured Persons in Families<sup>a/</sup>  
by Insurance Status of Other Family Members

	All Persons Number <sup>b/</sup> (in millions)	Percentage
All Persons in Families	21.0	100.0%
Coverage Status of Other Family Members		
Others Covered by Employer Plan	3.4	16.2
Others Covered by Non-group Plan	2.5	11.9
Others Covered by CHAMPUS	0.2	0.9
Others Covered by Medicaid	1.0	4.8
Others Covered by Medicare	1.4	6.7
No One Else in Family Covered	14.6	69.5

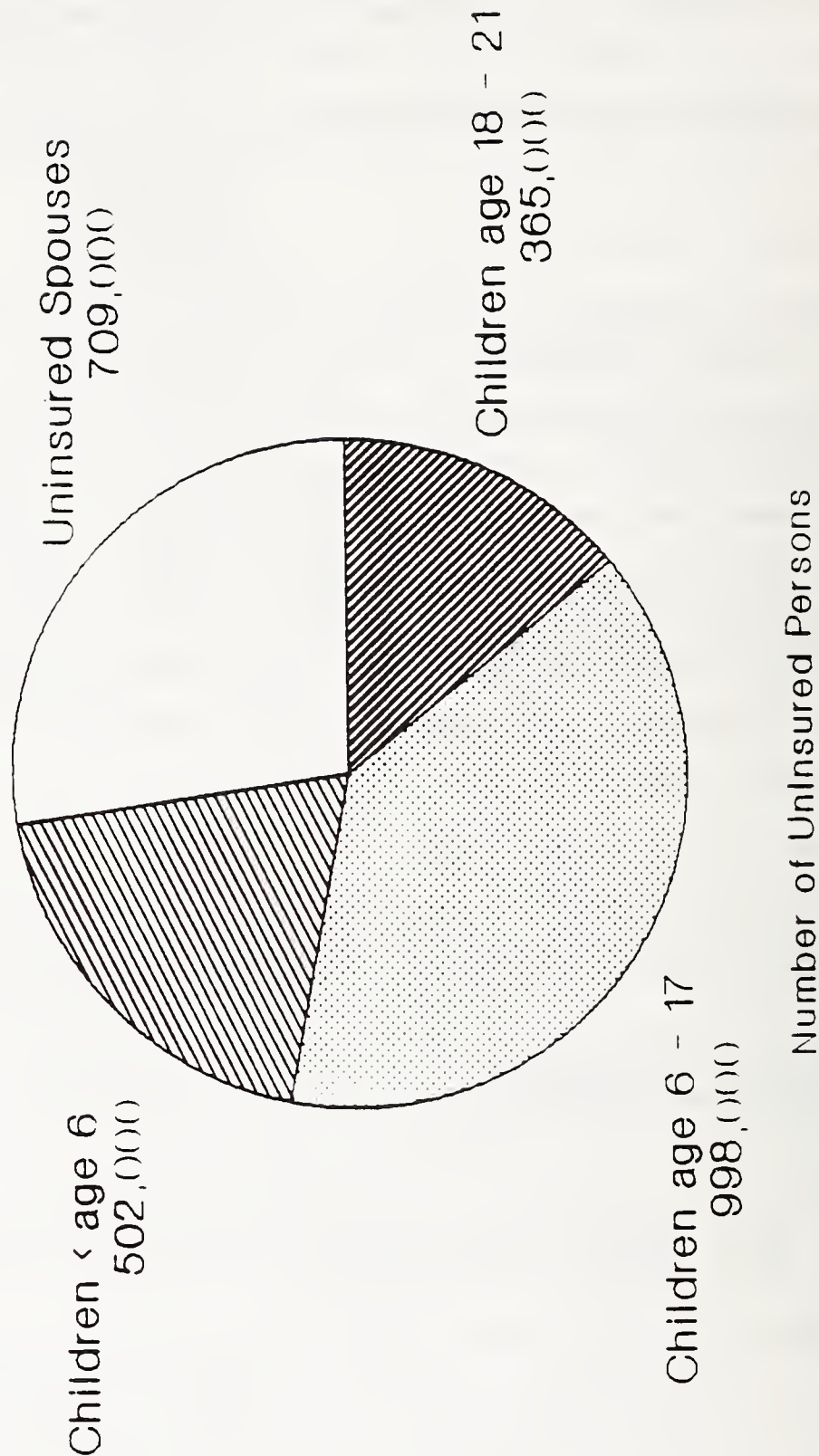
<sup>a/</sup> Persons in families include family heads, spouses, and children of family heads under age 22.

<sup>b/</sup> Numbers do not add to total population because other family members may be covered by more than one insurer.

Source: Preliminary estimates from the March 1988 Current Population Survey data, July 1, 1989. Subject to revision.

FIGURE 4

UNINSURED PERSONS WHERE FAMILY HEAD OR SPOUSE HAS EMPLOYER COVERAGE ON JOB  
(2.6 MILLION PERSONS)



SOURCE: Preliminary estimates from the March 1988 Current Population Survey (CPS) Data.



uninsured children and spouses (2.2 million of the 2.6 million) presumably could have been insured had the working family head or spouse been offered and elected family coverage under the employer plan.

Although it is possible that these individuals were employed on a job where family coverage was not available, the BLS Survey of employer health plans indicates that fewer than 0.5 percent of employer plans do not offer dependent health coverage to all participating workers (BLS, 1987). However, in many of these plans the employee is expected to pay the full cost of the family coverage option. While these dependents are most likely uninsured because the parent or spouse did not elect the family coverage option, some workers, particularly low-wage workers, may not have been able to afford the premium.

Three hundred sixty-five thousand children age 18 through 21 live in a family where the head or spouse has employer coverage on his/her job. While many of these persons 18-21 may be working, many may be uninsured not only because of limited access to employment-based insurance, but also because the employer family coverage option on their parent's plan does not extend coverage to children 18 or over who are not in school. This suggests that relaxing the age restrictions on dependents under employer plans could also slightly reduce the number of uninsured.

Another 2.5 million uninsured persons were in a family where other family members had non-group insurance coverage. This suggests that efforts to increase the number of persons obtaining family coverage through their employer or non-group plan could reduce the number of uninsured by up to 6 million persons.

Many uninsured persons were also in families where other family members were covered by a public health insurance plan. One million uninsured persons were in families where other family members were covered by Medicaid. Another 1.4 million uninsured persons were in a family where other family members were covered by Medicare. In addition, about 200 thousand uninsured

persons were in families where other family members were covered by CHAMPUS (Table 4).

### C. THE SIZE OF THE UNDERINSURED POPULATION

Estimates of the number of persons in private health insurance plans who are underinsured range from 12 to 20 million persons depending upon which definitions of underinsurance are used (Farley, 1985; US DHHS (ASPE), 1988; Lewin/ICF, 1988). The underinsured are generally defined as persons who are at risk of incurring "catastrophic" health care expenses even though they have health insurance. However, there is no uniform definition of underinsurance. For example, some define the underinsured as persons enrolled in a plan where there is a 5 percent or greater likelihood of incurring out-of-pocket health expenditures in excess of 10 percent of family income. Others have defined the underinsured as persons who lack coverage for specific types of health care such as primary and preventive care.

#### 1. Factors Which Determine Underinsurance

While underinsurance can be defined as confronting a specific dollar level of uninsured health expenses (e.g., \$15,000), it is usually defined in relation to income and assets, and often related to a level of family spending that may be considered "catastrophic" for the family. Typical thresholds that have been used in the literature are 5, 10, or 15 percent of family income in out-of-pocket health expenses (US DHHS (ASPE), 1988; Berki, 1986; Needleman, Anderson, and Jaffe, 1983). Thus, a family with income at the poverty level might confront catastrophic uninsured expenses at \$1,500, while a family with income in excess of \$100,000 may face catastrophic expenses, and thus be considered underinsured, only at levels of \$15,000 or higher. Because of the rare nature of high-expense illness and the strong relationship to income, most of those confronting catastrophic health expenses, either because of lack of insurance or underinsurance will be low income (Kasper et al., 1982).

The covered services and cost sharing rules of individuals' insurance plans generally determine whether they are underinsured. Some plans place limits on the amounts they will reimburse for certain types of care which can also result in underinsurance. Individuals can be underinsured if the plan cost sharing provisions fail to protect them from incurring catastrophic health expenses. For example, most private plans cover only charges for covered services in excess of a deductible amount which is typically about \$200 per year. In most plans the individual is also expected to pay a coinsurance amount for covered charges which is typically equal to about 20 percent of charges in excess of the deductible amount. An individual may be considered underinsured if the deductibles and coinsurance amounts under the plan are set sufficiently high that the individual is at risk of incurring large expenses relative to his/her income. In addition, some plans limit the amount of covered expenses annually or over a lifetime. For example, an individual may not be covered for expenses in excess of \$100,000 over his/her lifetime.

Thus, an individual may be considered underinsured if his or her health plan does not provide coverage for certain types of expensive health services that the individual is at risk of requiring (e.g., mental health, substance abuse). The plan could also underinsure if it places limits on the number of physician contacts or hospital days covered, as is often the case with mental health care and for some services covered by a number of state Medicaid programs.

## 2. Trends in Employer Health Plans Influencing Underinsurance

During the past decade, employers have made a number of changes to their health plans. More employers have limited the amount of cost-sharing required by employees. They are offering major medical coverage that limit the total amount that must be paid in coinsurance and deductibles. This extension of major medical coverage has likely reduced the rate of underinsurance, especially among middle and upper income workers. At the same time, employers have increased the amount of front-end cost sharing required by the



worker either in the form of higher premiums or increased coinsurance and deductibles. The increased front-end cost sharing requirements may have rendered some low-income persons underinsured. The actual impact of these trends on underinsurance is unclear.

Among medium and large firms sponsoring health insurance, the percentage of employees covered by plans with maximum cost sharing limits increased from about 20 percent in 1977 to about 82 percent in 1988 (BLS, 1989) (Figure 5). Nearly 7 out of 10 participants in health plans had an average maximum cost-sharing limit of less than \$2,500. One-half of participants have a cost sharing limit of less than \$1,000 while 25 percent have a limit of between \$1,001 and \$1,500. Only 10 percent of participants have a cost sharing limit greater than \$1,500. To illustrate the magnitude of this trend, only 3 years ago 90 percent of participants had cost-sharing limits greater than \$2,000 (BLS, 1989).

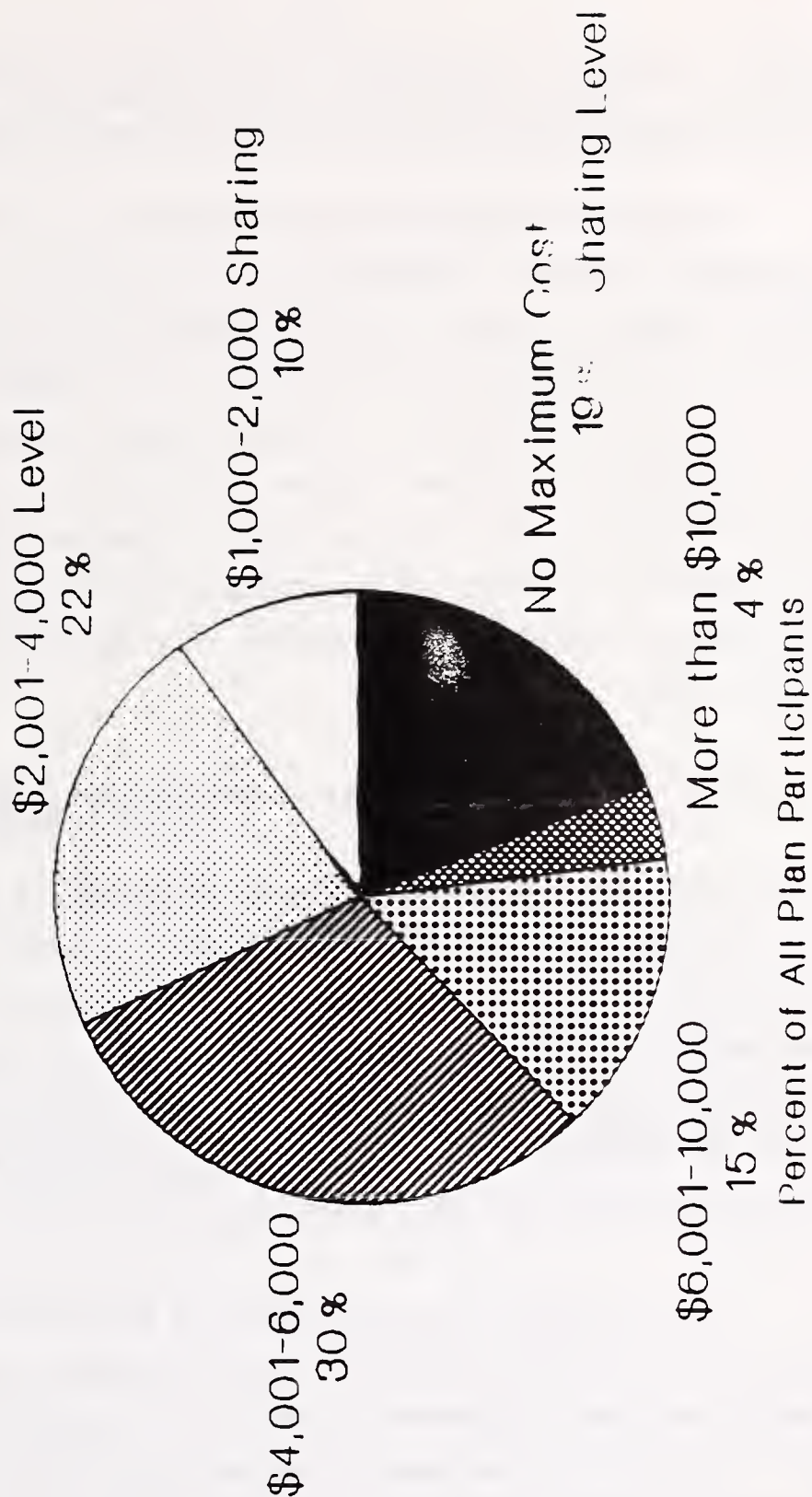
Employers are increasingly requiring employees to pay a larger portion of the premium for health insurance benefits. Since 1980, the proportion of employees whose health care premiums were wholly paid by their employer declined 21 percentage points (BLS, 1989). In addition, the annual deductibles in health insurance plans have increased substantially during the past decade and average \$153 per worker (BLS, 1989). These increases in cost-sharing may render some low-income persons underinsured if they cannot afford the deductible or coinsurance amounts.

Limits in cost sharing do not, however, protect individuals entirely from incurring catastrophic expenses. This is because the cost sharing limits apply only to covered services under the plan. Thus, an individual could still be considered underinsured if he/she uses services not covered under the plan. Services for alcohol, drug, and mental health care (particularly for debilitating mental health problems such as schizophrenia or severe depression) are typically in these categories. This has been one of the major factors in the push for state mandates to include coverage for these services in insurance plans. Long-term care services are also excluded from most



**FIGURE 5**

**DISTRIBUTION OF PARTICIPANTS IN LARGE  
AND MEDIUM FIRMS BY MAXIMUM COST SHARING  
LEVELS OF PLANS IN 1986**



SOURCE: Bureau of Labor Statistics,  
Employee Benefits in Medium and Large  
Firms, 1988, Department of Labor, 1987

insurance programs, and represent the largest category of uncovered services for the elderly.

Many plans reimburse for services only up to a maximum amount per person after which the individual is responsible for the full amount of charges. About 77 percent of participants in employer health plans sponsored by medium and large firms face a limit on the amount of reimbursement the plan will provide per participant. About 4 percent of plan participants are in plans which have a lifetime maximum of \$100,000 or less (Table 5). About 56 percent of all plan participants have a lifetime maximum of over \$500,000. This is twice the percent of plan participants with this limit in 1986. While these limits are high, a small number of individuals or families will exceed them in a year.

### 3. Estimates of the Number of Underinsured Persons

The most comprehensive work on estimating the number of underinsured persons was done by Farley (1985). Farley's study indicates that up to 20 million Americans under the age of 65 covered under private health plans are underinsured. The author estimated the number of persons under the age of 65 covered under private health insurance plans who were underinsured taking into account the expected levels of utilization for insured individuals, the coverage provisions of their plan and family income.

These estimates of the number of underinsured persons were developed using the 1977 National Medical Care Expenditures Survey (NMCES). These data include a nationally representative sample of persons insured under private plans which includes information on individual health expenditures, the coverage and cost sharing provisions of their health plans, and family incomes. Using the health plan provisions data in NMCES, Farley estimated the amount that individuals would pay in out-of-pocket expenses (those expenses incurred but not covered by insurance) under several scenarios of utilization (e.g., high, medium, and low levels of utilization) which are typical of persons

Table 5

Distribution of Participants in  
Large and Medium Firms by Lifetime Maximum Benefit Levels in 1988

	Percent of All Plan Participants
Lifetime Maximum	
\$100,000 or Less	4%
\$100,001-\$250,000	1
\$250,001-\$500,000	12
\$500,001-\$1,000,000	55
More than \$1,000,000	1
Annual or Disability Maximum Only	2
Both Lifetime and Annual or Disability Maximums	2
Without Maximum Limits	<u>23</u>
All Participants	100%

Source: Bureau of Labor Statistics, "Employer Benefits in Medium and Large Firms, 1988," U.S. Department of Labor, August 1989.

covered under private health plans. Farley applied two definitions of underinsurance, the second more stringent than the first:

- Persons who have a 5 percent or greater likelihood of incurring out-of-pocket health expenditures in excess of 10 percent of family income; and,
- Persons who have a 1 percent or greater likelihood of incurring out-of-pocket health expenditures in excess of 10 percent of family income.

The study found that 7.9 percent of all nonelderly persons covered under private health insurance plans had a 5 percent or greater chance of incurring out-of-pocket health expenditures in excess of 10 percent of income. About 13 percent had a 1 percent or greater chance of incurring expenses in excess of 10 percent of income. If Farley's percentages are applied to the number of Americans under age 65 who had private health insurance in 1987, the estimate of the number of underinsured would be between 12.6 million and 20.1 million persons under the age of 65.

The percentage of persons with group insurance who have a 5 percent or greater chance of incurring health expenses in excess of 10 percent of income were greatest among smaller groups. The number of uninsured under this definition varied from a high of 6.6 percent among groups with fewer than 25 employees to a low of 4.5 percent among those in groups of 2,500 members. This reflects that smaller employers, who typically pay higher premiums per enrollee than do larger groups, are more likely to elect less comprehensive coverage.

Persons enrolled in non-group plans were seven times as likely to be underinsured than were persons insured under group plans. About 36 percent of those covered under non-group plans had a 5 percent or greater likelihood of incurring expenditures in excess of 10 percent of income (Table 6). By comparison, only 5.1 percent of group plan participants were underinsured using this definition. These results reflect the less comprehensive health coverage of non-group policies. Typically non-group plans have higher cost



Table 6

Percentage of Privately Insured Persons Who Are Underinsured  
Under Alternative Definitions by Type of Insurance

	Five Percent Expectation of Out-of-Pocket Expenses in Excess of Ten Percent of Income	One Percent Expectation of Out-of-Pocket Expenses in Excess of Ten Percent of Income
Type of Private Insurance		
Non-group Insurance	35.8%	51.6%
Any Group Insurance	5.1	8.6
25 or fewer members	6.6	13.3
26-250 members	5.7	9.1
251-2,500 members	4.1	7.6
Over 2,500 members	4.5	7.1
All Privately Insured Persons	7.9%	12.6%
Estimated Number of Underinsured Persons in 1988 <sup>a/</sup> (in millions)	12.6	20.1

<sup>a/</sup> Estimated by applying author's estimates of the percentage of underinsured persons in 1984 to the number of persons covered under private health plans in 1988.

Source: Pamela J. Farley, "Who Are the Underinsured?", Milbank Memorial Fund Quarterly/Health and Society, Vol. 63, No. 3, 1985.

sharing, lower lifetime limits and stop-loss, and fewer covered services than group plans. The more limited coverage of these plans reflects both limitations in the non-group products offered and the greater attractiveness of more limited and lower cost policies to those who must pay the full cost out-of-pocket.

For those privately insured, the likelihood of being underinsured is directly related to family income. Using the 5 percent risk definition, nearly one-half of the poor and near poor in the Farley analysis were at risk of being underinsured. Thirteen percent of other low income were underinsured. By contrast, only 2.3 percent of high income people had a 5 percent risk of expenses in excess of 10 percent of income (Table 7).

The age group at the greatest risk of being underinsured is persons 55 to 64. Farley estimates that 20 percent of this age group had a 5 percent or greater chance of incurring out-of-pocket expenses in excess of 10 percent of income. The underinsurance rate among those age 55 through 64 is explained partially by the higher levels of utilization among this age group compared to younger individuals. Even more important, however, is that a larger proportion of privately insured individuals in this age group are enrolled in non-group plans where coverage is less comprehensive. The 1988 CPS reports that among those with private health insurance, the percentage of persons with non-group coverage was about 19 percent for those age 55 through 64 compared with only about 11 percent among those under age 55.

The Farley analysis also indicated that the second highest level of underinsurance occurred among persons age 19 through 24. Eleven percent of this age group had a 5 percent or greater chance of having out-of-pocket expenditures in excess of 10 percent of income compared with only about 7.9 percent for all privately insured persons under the age of 64. This relatively high rate of underinsurance among this age group occurs in part because one quarter of those with private insurance are enrolled in non-group plans. Also this age group tends to be lower income than older groups and out-of-pocket expenses as a percentage of income tends to be greater.

Table 7

Percentage of Privately Insured Persons Who Are Underinsured  
Under Alternative Definitions by Age, Sex, and Income

	Five Percent Expectation of Out-of-Pocket Expenses in Excess of Ten Percent of Income	One Percent Expectation of Out-of-Pocket Expenses in Excess of Ten Percent of Income
<u>Age</u>		
Under age 19	5.4%	9.1%
19-24	10.9	17.5
25-34	6.1	10.8
35-54	6.0	10.9
55-64	19.9	25.0
<u>Sex</u>		
Males	6.4	10.8
Females	12.2	17.7
<u>Family Income</u>		
Poor and Near Poor	48.2	56.2
Low Income	13.2	21.9
Middle Income	5.2	9.8
High Income	2.3	5.1
<u>All Privately Insured Persons</u>	7.9%	12.6%

Source: Pamela J. Farley, "Who Are the Underinsured?", Milbank Memorial Fund Quarterly/Health and Society, Vol. 63, No. 3, 1985.

Women were about twice as likely to be underinsured as were men (Table 8). Twelve percent of women who had a 5 percent or greater chance of having out-of-pocket expenditures in excess of 10 percent of income compared with only about 6 percent among men. Women have higher health care use than men (due to pregnancy and reproductive health needs). They also typically have lower incomes than do men so that out-of-pocket expenses as a percentage of income tends to be greater. As shown in Table 8, the incidence of underinsurance tended to be greatest among privately insured persons in lower income groups.

More recent estimates of the number of underinsured were reported in the Department of Health and Human Services study of catastrophic illness.<sup>2</sup> This study estimated the risk of uninsured catastrophic expenses for families experiencing high medical expenses. While the DHHS study relied on the 1977 NMCES data, it used data on health care coverage and changes in the national health account to adjust the data to reflect changes from 1977 to 1987. The findings were similar to Farley's for families in which the head of family was employed; substantially higher for families in which the head of family was unemployed. Differences were attributed to variations in the definition of insured families, scope of medical expenses covered, and the impact of insurance coverage on utilization (US DHHS, 1988). To fully understand the impact of recent changes in employer health plans, health care utilization, and employment changes on underinsurance, the Farley analysis should be redone once the 1987 NMES data become available.

#### D. CONSEQUENCES OF UNINSURANCE AND UNDERINSURANCE

While it is often stated that the uninsured do not have access to the health care system, this is an overstatement. Both the uninsured and underinsured use a substantial amount of health services. Despite this use,

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<sup>2</sup> Since the DHHS study examined the characteristics of persons with high-expense illness, the synthesis does not specifically address this issue.



Table 8

Use of Health Services Among the Sick by Selected Insurance  
Categories for the Poor and Near Poor, 1977

Indicators of Health Status and Use of Services		Overall Average	Always Medicaid	Sometimes Medicaid, Otherwise Insured*	Sometimes Medicaid, Otherwise Uninsured	Always or Sometimes Private Insurance**	Always Uninsured
I. More Than 8 Bed Days							
Average physician visits	7.1	8.1	8.2	6.2	7.0	4.6	
Average nonphysician visits	2.4	3.9	1.7	2.5	1.8	1.0	
Average number of prescription drugs	10.6	11.6	15.4	6.1	11.3	5.9	
Average hospital	.67	.64	.82	.58	.73	.45	
II. Fair Or Poor Perceived Health Status							
Average physician visits	6.0	7.1	6.6	5.2	5.7	3.9	
Average nonphysician visits	2.0	2.8	2.1	1.3	2.0	0.6	
Average number of prescription drugs	11.3	12.1	15.1	6.8	12.9	5.6	
Average hospital	.3	.33	.32	.19	.33	.20	
III. With Limited Activity							
Average physician visits	7.5	9.7	6.2	5.9	7.2	3.8	
Average nonphysician visits	2.0	2.8	1	0.9	2.1	0.8	
Average number of prescription drugs	15.3	16.7	15.6	10.6	16.4	6.9	
Average hospital	.40	.39	.34	.32	.47	.18	

\* Includes private, Medicare and others.

\*\* Also includes individuals who had only Medicare.

Source: Wilensky and Beck, "Poor, Sick, and Uninsured, Health Affairs (Summer 1983). Data from NMCES.

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questions remain about the health and financial dimensions of the care received by the uninsured and underinsured.

With respect to access to care, we must ask whether a shortfall in health care remains and what are its consequences: Is the care received by these populations sufficient? What are the consequences of limited access on health status? How much would it cost to close the gap in access?

A second set of issues relates to the financial impact of the care the uninsured do receive: How is this care financed? What burden does paying for this care impose on the uninsured, health care providers, government and others in the health care system?

This section examines the health and financial consequences of being uninsured from the perspective of the individual or family without coverage. (Later sections review the impact on other aspects of the health care system.) The uninsured and underinsured, when confronted with a health problem, have three choices: 1) postponing or foregoing care; 2) paying out-of-pocket; and 3) seeking care at reduced or no charge. Analyses suggest they exercise all three choices. Each of these decisions have specific implications for the families in terms of access to care, health status, and financial status.

#### 1. Postponed or Foregone Care

The uninsured and underinsured may postpone or forego care. This has the attendant risk of leading to more severe health conditions. They may defer care for three reasons: 1) they lack the financial resources to obtain care and may be reluctant to accept charity and therefore wait until they are seriously ill; 2) they may lack a usual source of care and not have an entry point when confronting an acute problem; and 3) they may lack knowledge of the importance of preventive or primary care. The uninsured who defer care often obtain treatment for conditions at later stages in their illness. This can be costly to the individual, in terms of a more serious illness and time lost

from work, and costly to the health care system because of greater expenditures associated with treating conditions in more advanced stages.

This section examines access to care among the uninsured and compares the utilization of the uninsured to the insured to determine whether their utilization experience suggests that the uninsured are postponing or foregoing care. It also explores the health status consequences of lack of insurance and deferred care.

#### a. Access to care

One of the consequences of uninsurance is reduced access to care. One measure of access is having a usual source of care. The uninsured are less likely to have a usual source of health care than the insured. The 1982 Robert Wood Johnson Foundation Access Survey found that 22 percent of the uninsured reported not having a usual source of health care, while only about 10 percent of the insured reported this. While the insured are more likely to have a usual source of care than the uninsured, the type of insurance influences their site of care. The publicly insured are as likely to identify a usual source of care as the privately insured, but are more likely to identify this source as a hospital-based provider (Figure 6).

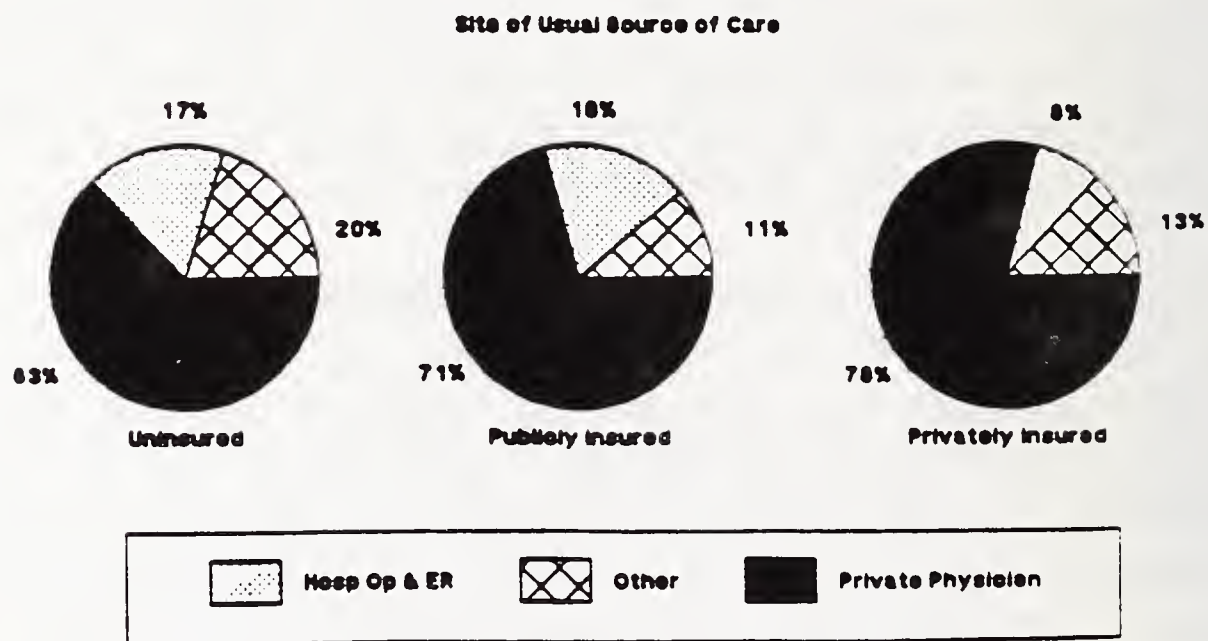
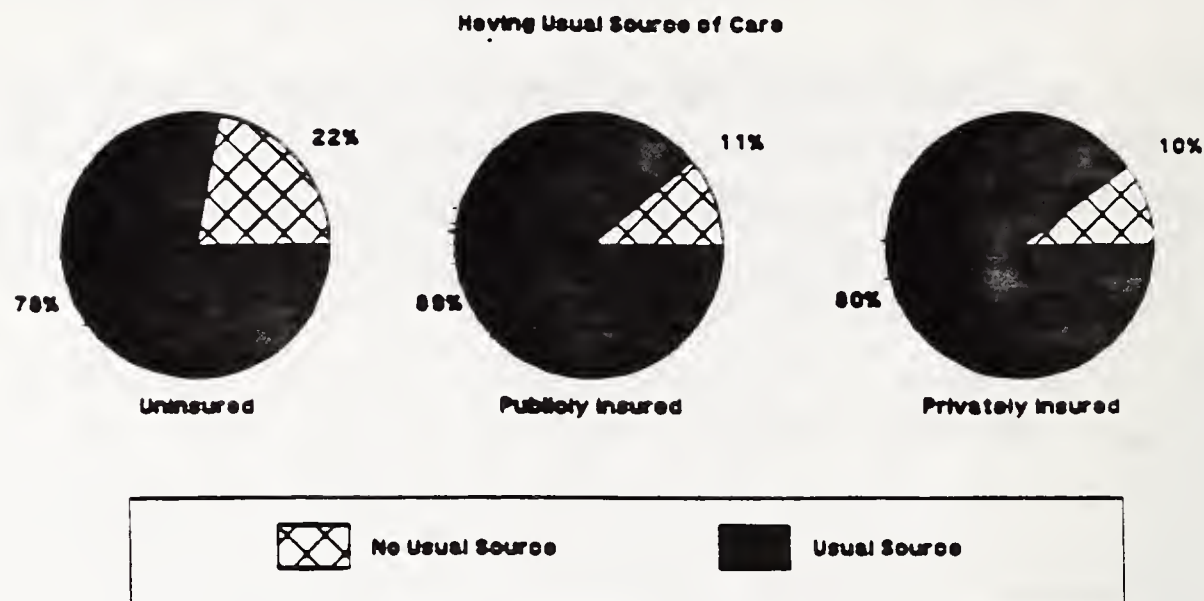
In contrast, when site of care was examined for low-income children, a recent study analyzing NMCUES data found that Medicaid children were more likely than both low-income privately-insured and uninsured children to visit an office-based physician (Rosenbach, 1989). About 51 percent of Medicaid children visited an office-based physician in 1980 compared to 44.5 percent of the low-income privately-insured and 47 percent of the uninsured. The lower use of office-based physician services among low-income children with private insurance may be partly explained by the limited scope of benefits covered by their policies.

Survey data indicate the uninsured are foregoing care. The uninsured are three times more likely than the uninsured to report someone in their family needed health care but did not obtain it (15 percent compared



FIGURE 6

**THE PUBLICLY INSURED POPULATION RESEMBLES THE PRIVATELY INSURED POPULATION IN HAVING A USUAL SOURCE OF CARE, BUT RESEMBLES THE UNINSURED IN THE SITE OF CARE**



Source: Lewin/ICF Tabulations from the Robert Wood Johnson Foundation Access Survey, 1982.



with 4.8 percent). When asked whether their family had been refused care for financial reasons, 3.6 percent of the uninsured responded "yes" compared with 1.3 percent of the insured (Access to Health Care in the United States, 1982). The 1980 NMCUES data indicate that 8.9 percent of non-elderly uninsured persons had experienced a health care condition during the year for which they would have liked to have obtained medical care but decided not to do so. By comparison, only 5.0 percent of those with insurance reported they did not obtain care. Among those who reported they did not obtain care for a health condition, about two-thirds of those without insurance indicated that they thought the care would cost too much while only about one-third of insured persons cited cost as the reason for failing to obtain care.

#### b. Utilization of health care

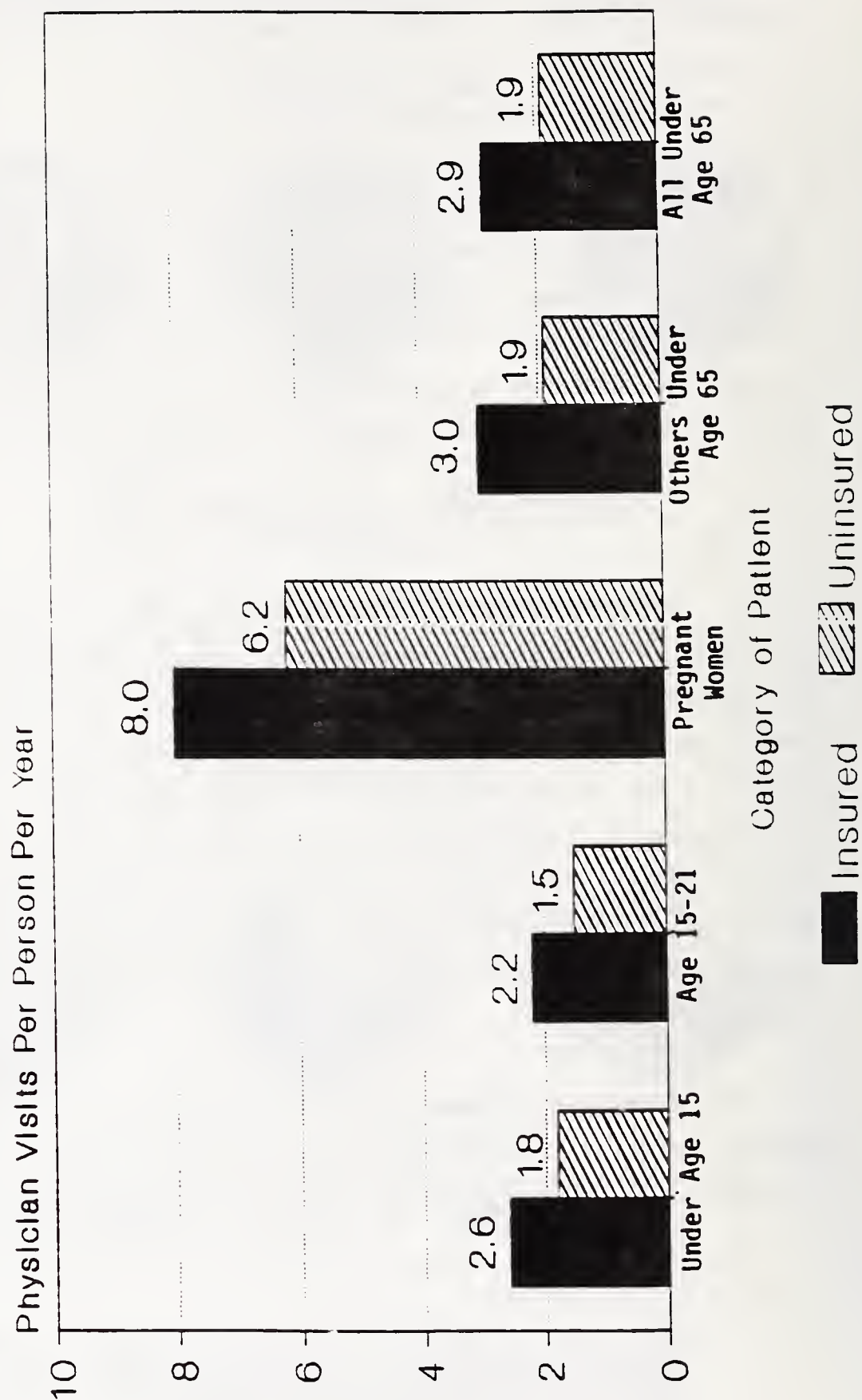
Health expenditure survey data reinforce the self-reported access problems. The uninsured consume fewer health care services than the insured. For example the uninsured have substantially fewer physician office visits per person than do insured persons at all age levels.<sup>3</sup> Overall uninsured persons under the age of 65 have one-half as many physician office visits per person as the insured. Among children under the age of 15, the uninsured had an average of one-third fewer physician visits per person per year than those with insurance (Figure 7). For children age 15 through 21, physician visits per person were about 1.5 for the uninsured and about 2.2 for those with insurance.

Uninsured pregnant women have about 23 percent fewer physician office visits per person compared to insured pregnant women (Figure 7). Another study conducted by the Children's Defense Fund found that three times

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<sup>3</sup> The estimates presented here are based upon expenditure and utilization data provided in the 1980 National Medical Care Utilization and Expenditures Survey (NMCUES), updated to reflect trends in utilization, health expenditures and population characteristics between 1980 and 1988. Therefore, the utilization and expenditures data presented here should be considered projections from historical data rather than analyses of actual survey data for 1988.

**FIGURE 7**  
**PHYSICIAN VISITS BY AGE, PREGNANCY STATUS,**  
**AND INSURED STATUS**



as many uninsured women as insured women received delayed prenatal care. This was a particular problem for uninsured black women who were one-third more likely to receive delayed prenatal care as uninsured white women (Children's Defense Fund, 1989). Since prenatal care has been demonstrated to reduce the risk of low birthweight, the long-term financial benefits of extending coverage to this group may far outweigh the short-term costs of extending prenatal care to these women.

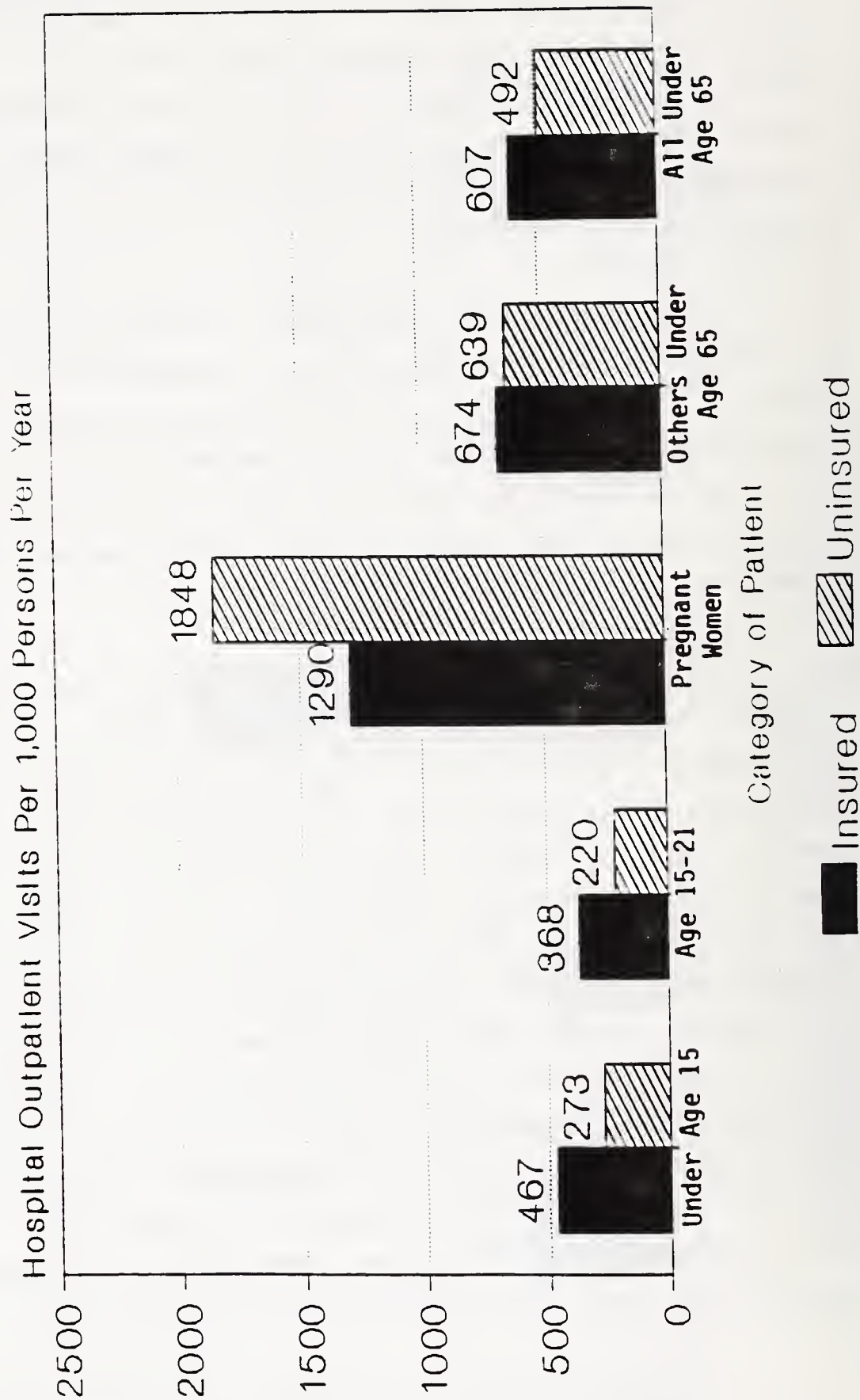
While some of the difference in use may reflect differences in health status, other studies which have controlled for health status have found these patterns persist when both income and health status are controlled (Newachak, 1986). Analysis of the NMCES data for the poor and near poor disclosed substantially lower use of physicians among the uninsured even for those in poor or fair health, or other indications of health problems (Table 8).

Hospital outpatient utilization, which might be expected to substitute for physician care among the uninsured, is also substantially lower for the uninsured than the insured among all groups except pregnant women. Outpatient visits among persons under age 65 were about 492 visits per 1,000 persons for the uninsured compared with about 606 visits per 1,000 persons among those with insurance (Figure 8). However, among pregnant women, the uninsured had about 1,848 outpatient contacts per 1,000 persons (1.8 visits) compared with only about 1,291 outpatient contacts per 1,000 insured persons (1.3 visits). These data suggest that many uninsured pregnant women may be substituting outpatient care for physician care. This may occur because treatment in the outpatient setting is less expensive than physician office visit care or because they do not have access to a private physician or non-hospital clinic. While some pregnant women appear to be substituting outpatient visits for physician office visits, the use of hospital outpatient services does not close the gap in physician visits for this population.

The uninsured also obtain fewer preventive services than the insured. A study of 10,000 middle-aged women from the National Health Interview Survey found that basic screening for four major illnesses was



**FIGURE 8**  
**HOSPITAL OUTPATIENT VISITS BY AGE,**  
**PREGNANCY STATUS, AND INSURED STATUS**





significantly less for uninsured women than for those who had insurance. The preventive services include Pap tests to detect cervical cancer, blood pressure check ups, breast exams, and glaucoma tests. The proportion of uninsured women receiving blood pressure checks was 7 percent below the proportion of insureds; the proportion for all other services was 14-15 percentage points below the insured (Table 9). These uninsured women are likely to be low-income and at higher risk for the diseases these tests detect (Woolhandler and Himmelstein, 1988).

Other studies have found that loss of insurance coverage resulted in reductions in access to ambulatory health care. A study of a sample of medically indigent adults who lost their eligibility for Medi-Cal and had no other form of insurance found that after a one year follow-up of these persons there was a substantial reduction in the number who reported having a regular physician. In terms of health status, it found that among hypertensives, those who lost coverage had a significant increase in blood pressure compared to those who remained covered (Lurie 1986).<sup>4</sup>

The Rand Health Insurance Experiment (HIE) had mixed results on the impact of free care on health status. Overall it found that providing free care did not have an impact on health status. However, there were two notable exceptions: 1) free care resulted in lowering blood pressure compared to persons with some level of coinsurance; and 2) adults with impaired vision at point of entry into the program were reported to have improved corrected vision. Both results were stronger among poor recipients (Lohr, et. al., 1986). The failure to find differences in the other events may be due to the limited power of the design to detect differences in infrequent events. Moreover, since all the participants in the HIE were insured, the ability to draw

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<sup>4</sup> This was a study of those already in treatment. It does not consider differences in entering treatment due to limited insurance.

Table 9

Percentage of Women Who Do Not Obtain Basic Diagnostic Tests

Test	Overall	Insured	Uninsured
Blood Pressure Checkup	12%	11%	18%
Pap Smear	27	25	39
Breast Exam	38	36	50
Glaucoma Test	30	28	43

Source: Woolhandler and Himmelstein, Journal of the American Medical Association, May 20, 1988.

conclusions about the access problems of the low income uninsured may be limited.

A recent NCHSR study found that charging members of prepaid group health plans a small copayment for office visits may significantly reduce use of primary care services. The study found that office visits to primary care physicians at clinics operated by a Seattle-based health maintenance organization fell 11 percent after the plan began charging members a \$5 copayment fee (Cherkin, Grothaus, and Wagner, 1989). Whether this reduction in office visits represents reduced access or a reduction in inappropriate visits is unclear, since the study did not examine the impact of reduced utilization on health status.

Utilization of inpatient hospital care by the uninsured is also substantially lower than among insured persons. Hospital admissions per 1,000 persons under age 65 were 89.2 for uninsured persons compared to 125.9 for those with insurance. Hospital utilization was lower for uninsured persons than among those with insurance for all groups including pregnant women (Figure 9). The lower hospital use among uninsured pregnant women may result because these women are less likely than insured women to carry to full-term or more likely to have their babies at home. NMCES also reports a pattern of lower hospitalization among the uninsured even for those uninsured in poor health (Table 8).

The net result of lower health care utilization is lower aggregate spending on health care for the uninsured. In 1988, average per capita spending for the uninsured was \$866 compared with \$1,457 for the insured. Spending was lower for every type of service (Table 10).

#### c. Avoidable hospitalization

Two studies by Lewin/ICF, one for the District of Columbia Hospital Association and one for the Health Resources and Services Administration, found higher rates of avoidable hospitalizations for preventable conditions

**FIGURE 9**  
**HOSPITAL ADMISSIONS BY AGE, PREGNANCY**  
**STATUS, AND INSURED STATUS**

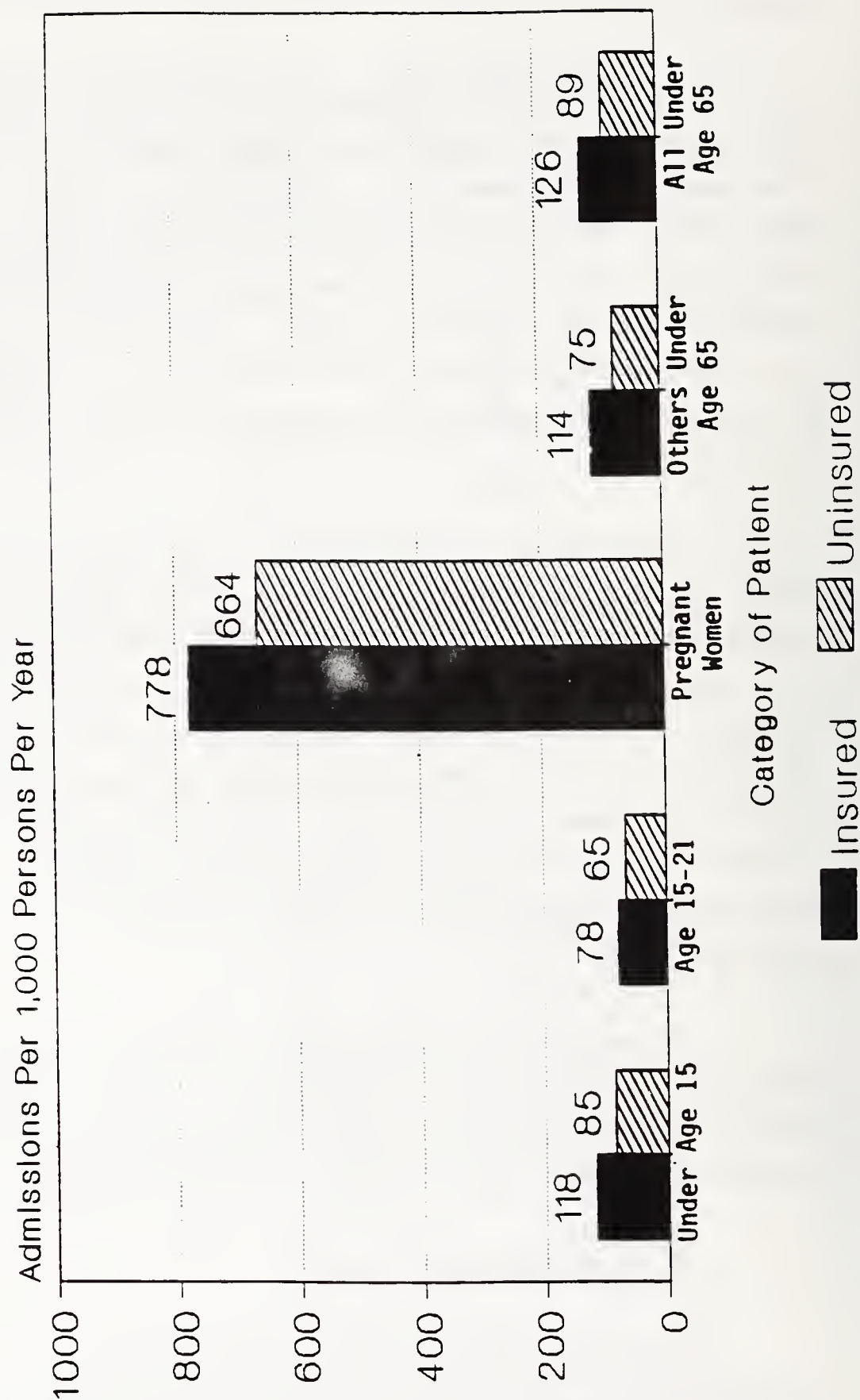




Table 10

Per Capita Personal Health Care Expenditures for Non-Institutionalized  
Non-elderly Persons by Type of Service in 1988

	Insured Persons		Uninsured Persons	
	Per Capita Expenditures <sup>a/</sup>	Percentage of Total Expenditures	Per Capita Expenditures <sup>a/</sup>	Percentage of Total Expenditures
Hospital Inpatient	\$ 396	27.2%	\$313	36.0%
Hospital Emergency Room and Outpatient	143	9.8	90	10.3
Physicians Office Visits	459	31.6	239	27.6
Dentists	212	14.5	91	10.7
Other Professional	81	5.6	31	3.4
Prescription Drugs and Medical Sundries	92	6.3	67	7.8
Eyeglasses and Appliances	40	2.7	22	2.5
Other Health Care	<u>34</u>	<u>2.3</u>	<u>13</u>	<u>1.7</u>
Total	\$1,457	100.0%	\$866	100.0%

<sup>a/</sup> Excludes administrative costs and profit.

**Lewin/ICF**

Source: Lewin/ICF estimates using the Health Benefits Simulation Model using the 1980 National Medical Care Utilization and Expenditures Survey (NMCUES), aged to depict 1988.

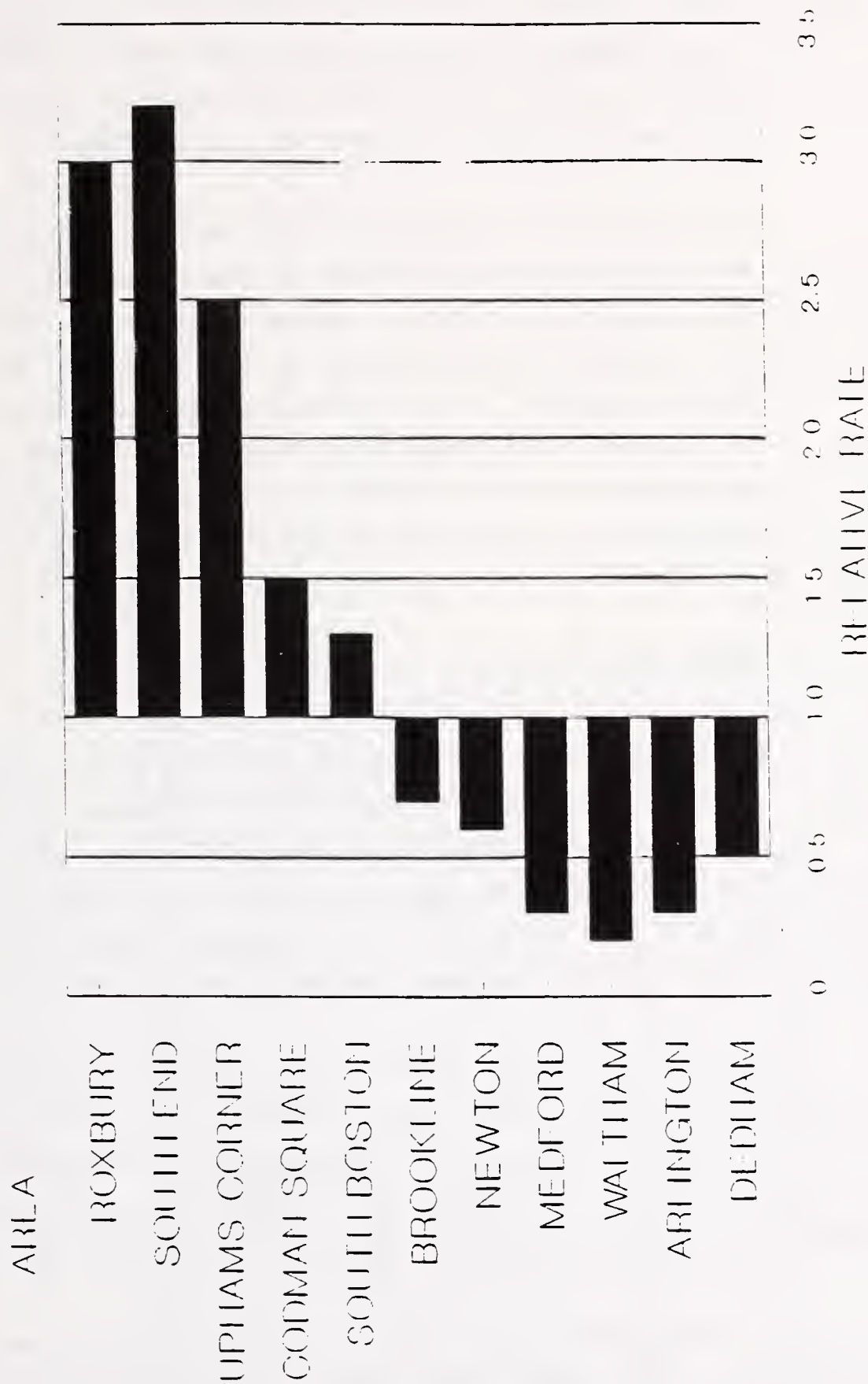
among populations from lower income areas (Lewin/ICF 1986, 1988). While these studies did not examine the uninsured per se, the low-income areas are likely to have both lower insurance coverage and less access to providers than higher income areas. Hospital admission rates for a set of diagnoses that could be prevented with access to adequate primary care were analyzed by patient residence for the District of Columbia, Boston, and Baltimore. Figure 10 shows rates of uncontrolled hypertension from neighborhoods in the Boston area. Rates above 1.0 indicate that the area has higher rates of uncontrolled hypertension than the overall area average. The areas are ranked by percent of the population below poverty. As shown, high poverty areas have substantially higher rates of uncontrolled hypertension than low poverty areas. For example, the rate of uncontrolled hypertension in the South End is approximately 16 times higher than the rate in Medford. These results are consistent with findings in Baltimore and the District of Columbia for this and the other conditions studied. While we would expect to observe higher hospital admission rates for uncontrolled hypertension in high poverty areas, since these areas have higher underlying rates of hypertension, a 16-fold difference is too high to be explained by differences in the underlying rate. These differences in rates for avoidable hospitalization reinforce the conclusion that the poor have less access to primary health care services.

The D.C. Hospital Association study also found that hospitalization rates for discretionary conditions were somewhat lower than expected for the poorer neighborhoods. This provides additional support for the findings from NMCES and NMCUES that rates of hospitalizations are lower among populations with less financial access to care.

A recent study in Boston examined the differences in treatment between the insured and the uninsured once hospitalized. The study found that the uninsured receive less treatment once they are hospitalized than the insured. Controlling for severity of illness, the uninsured were discharged earlier and underwent fewer medical procedures than patients insured by Blue Cross. Compared with Medicaid patients, they were discharged earlier but had similar rates of medical procedures. The lower utilization does not

FIGURE 10

## UNCONTROLLED HYPERTENSION IN BOSTON



Source: Lewin/ICF analysis of Massachusetts Hospital Discharge Data, 1986.



necessarily indicate that the uninsured are receiving inadequate care. The reasons for the differences in care are unclear. It may be that the providers are aware of the patient's insurance status and provide different services or that the patients themselves exert some influence over their hospital care to avoid expensive medical bills (Weissman and Epstein 1989).

In contrast, when the Hospital Trustees of New York State reviewed 1986 data describing the average length of stay in hospitals for the uninsured as compared to those with private or public insurance, it was determined that the medically indigent, on average, had a longer length of stay in almost every diagnostic category. This study also found that the uninsured were less likely to be admitted to hospitals than persons with private insurance. The study concluded that the longer length of stay could be explained by the fact that the uninsured are likely to be sicker than the insured once hospitalized because they defer treatment (Hospital Trustees of New York, 1987).

## 2. Out-of-Pocket Payments

The second option facing the uninsured is to pay for care out-of-pocket. Average out-of-pocket expenditures for uninsured persons are less than for insured persons. From the adjusted NMCUES data, we estimated that out-of-pocket expenditures per person in 1988 were about \$430 for uninsured persons and about \$463 for persons with insurance. NMCES data for the poor and near poor from 1977 also show the same pattern (Table 11).

Large out-of-pocket expenses are a particular risk for persons with high-expense illnesses, such as AIDS. One study found that persons with AIDS and their families are estimated to be paying about 20 percent of the cost of health care out-of-pocket (Pascal et. al, 1989). These high out-of-pocket payments may place large financial burdens on low-income families.

At all income levels, families with one or more members who are uninsured have lower total average out-of-pocket expenses per family than do families where all family members are insured. In 1988 there were 10.9



Table 11

## Financial Burden of the Poor/Near Poor Population by Insurance Status, 1977

Indicators of Health Status and Use of Services	Average Per Person	Always Medicaid	Sometimes Medicaid, Otherwise Insured*	Sometimes Medicaid, Otherwise Uninsured	Always or Sometimes Private Insurance**	Always Uninsured
Out of Pocket Expenses (dollars)						
Average out-of-pocket expenses	\$136	62	132	54	183	136
Average out-of-pocket expense plus self-paid premiums	\$165	62	171	54	236	136
Use of Free Care (percent)						
As percentage of hospital stays	4	5	0	8	2	12
As percentage of ambulatory physician visits	9	5	7	10	10	20
As percentage of ambulatory nonphysician visits	20	11	38	12	23	41

\* Includes private, Medicare and others.

\*\* Also includes individuals who had only Medicare.

Source: Wilensky and Beck, "Poor, Sick, and Uninsured, Health Affairs (Summer 1983). Data from NMGES.

million nonelderly families where one or more family member is uninsured (Table 12).<sup>5</sup> Average out-of-pocket expenditures for families with one or more uninsured member were about \$968 compared with about \$1,292 for nonelderly families where all members are insured.

Out-of-pocket spending for the uninsured is lower than among those with insurance for several reasons: the uninsured use fewer health care services than do those with insurance; they do not bear a share of premium costs for their insurance; and the uninsured pay out-of-pocket for only about half of the care they receive. (The rest of their care is paid by charity care, county hospitals, general assistance and other public sources (Figure 11).) In addition, the insured generally have higher incomes than do the uninsured so that they are more likely to obtain some forms of health care that may not be covered by insurance such as dental care and mental health services.

Per capita and per family measures of out-of-pocket expenditures can be misleading. Out-of-pocket health expenditures, while lower in dollar terms, are higher as a percentage of family income among families with uninsured members than among families where all members are insured (Berki, 1986). Furthermore, the risk of very high expenses as a percent of income is much greater for families without insurance. About 9 percent of all families with one or more uninsured family member had out-of-pocket expenses in excess of 30 percent of total family income, compared with only 2 percent of families where all members are insured (Table 13). Approximately 38 percent of families with uninsured members had out-of-pocket expenses greater than 5 percent of family income, compared with one-quarter of insured families.

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<sup>5</sup> In this analysis, nonelderly families and unrelated individuals are defined as families and unrelated individuals where the family head or unrelated individual is under the age of 65.

Table 12

Estimated Average Annual Out-of-Pocket Expenditures  
Per Family for Non-elderly Families, 1988<sup>a/</sup>

Family Income as a Percentage of the Poverty Threshold	Average Out-of-Pocket Expenses Per Family		Percentage Difference from Families with Insurance
	All Family Members Insured	Some or All Family Members Uninsured	
Below Poverty	\$1,137	\$ 935	-17.8%
100-149%	1,344	980	-27.1
150-199%	1,422	865	-39.2
200-299%	1,287	987	-23.3
300% +	<u>1,305</u>	<u>1,205</u>	<u>-7.7</u>
All Families	\$1,292	\$ 968	-25.1
Number of Families (in millions)	68.8	10.9	N/A

<sup>a/</sup> For this analysis, non-elderly families are defined as families and unrelated individuals where the family head or unrelated individual is under age 65.

**Lewin/ICF**

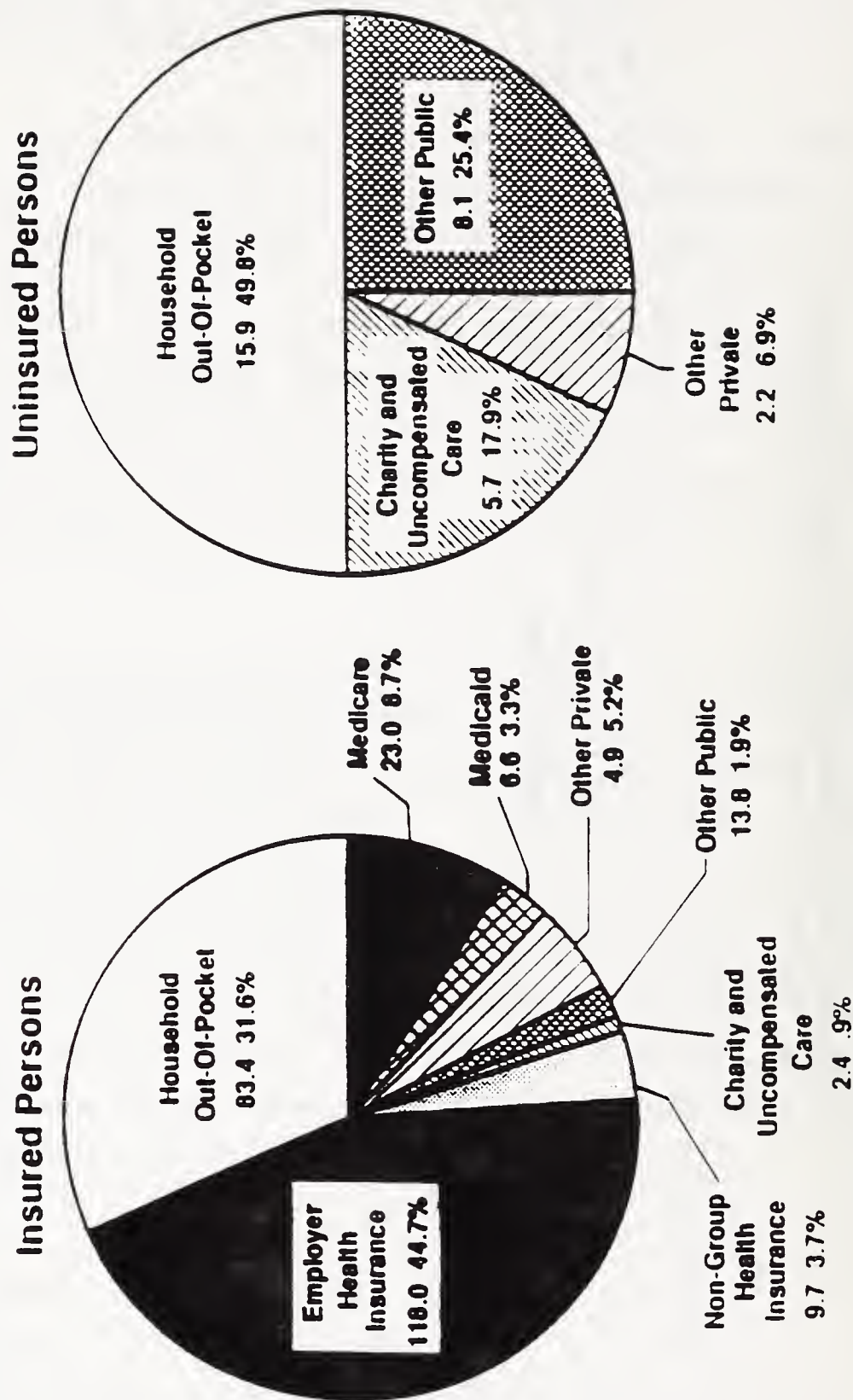
Source: Lewin/ICF estimates using the Health Benefits Simulation Model using the 1980 National Medical Care Utilization and Expenditures Survey (NMCUES) aged to depict 1988.

FIGURE 11

# ESTIMATED PERSONAL HEALTH CARE EXPENDITURES FOR NON-INSTITUTIONALIZED NON-ELDERLY PERSONS BY SOURCE

## OF PAYMENT

(In Billions of Dollars)<sup>a</sup>



<sup>a</sup> - Excludes administrative costs.

Source: Lewin/ICF estimates from the Health Benefits Simulation Model (HBSM) using the



Table 13

Distribution of Families by Estimated Out-of-Pocket Expenditures as a Percentage of Family Income  
for Non-elderly Families by Insured Status of Family Members

	Families Where All Members Are Insured	Families Where Some or All Members are Uninsured
Out-of-Pocket Expenditures for Health Care As a Percentage of Family Income		
<5 %	75.5%	62.6%
5-10%	14.6	14.4
10-20%	6.3	12.3
20-30%	1.6	1.8
30% or more	<u>2.0</u>	<u>8.9</u>
All Families	100.0%	100.0%

<sup>a/</sup> In this analysis, non-elderly families are defined as families and unrelated individuals where the family head or unrelated individual is under age 65.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model using the 1980 National Medical Care Utilization and Expenditures Survey (NMCUES) aged to depict 1988.

### 3. Reduced or No Charge Care

The third option confronting the uninsured and underinsured is to seek care at reduced or no charge from providers who are willing to discount their charges. These may include hospitals, community health centers, public health departments, physicians, and other providers. Data on the extent of discounted care are limited.

Wilensky and Berk (1983), using a narrow definition of free care sources (public hospitals, public clinics) found low income uninsured use these sources at twice the average rate for low income persons (Table 11). This analysis did not consider charity or discounted charges by other providers, care underwritten by such programs as Maternal and Infant Care at private health facilities, or care at VA facilities.

An analysis of the NMCUES data suggests that half the costs of the care of uninsured are paid by others (Figure 11). Approximately 18 percent of the care received by the uninsured is provided in the form of charity care by hospitals while 25 percent is provided by county hospitals, state general assistance and other public sources.

Among the non-elderly insured population under age 65, by contrast, private health insurance covered nearly half of the cost of all personal health care received. Public health insurance covered about 14 percent of this care, less than 1 percent was provided in the form of charity or uncompensated care, and about 32 percent was paid by families in out-of-pocket expenses. For all the care received by these persons, 44.7 percent was paid through employer health insurance while about 3.7 percent was covered under non-group plans. Medicaid accounted for about 8.7 percent of expenditures while Medicare paid for about 3.3 percent of the care received.

One of the consequences of lack of insurance is greater reliance on providers who can obtain the funding to subsidize care. Often, these are hospitals. Expenditure data indicate substantial differences between the

insured and uninsured populations in the types of health care services consumed. For example, about 36 percent of all health spending by the uninsured was for hospital care while among insured persons hospital care accounted for only about 27 percent of total health expenditures. Physician's care constituted about 28 percent of all health expenditures by the uninsured while it was about 32 percent for the insured (Table 10).

National household surveys sponsored by the Robert Wood Johnson Foundation have shown that, while most of the uninsured identify private physicians as their usual source of care, they are twice as likely to rely on hospital emergency rooms as their usual source of care than the insured (Aday, 1984). The uninsured rely on hospitals to a greater extent because hospitals are more able and willing to finance this care through direct contracts, philanthropic fund raising, and cost shifts.

The reliance of the uninsured on hospital-based care has implications for the quality, continuity, and cost of care received by this population. Those who receive care in the emergency room rarely establish a relationship with one health provider, and emergency rooms and outpatient departments are less likely to be organized to provide ongoing preventive care and management of chronic diseases. Heavy reliance on this form of ambulatory care delivery may suggest that services are not provided in an appropriate and timely way.

An important issue in the use of emergency rooms is the extent to which they are used for primary care as opposed to urgent care. A study of emergency room use conducted by the Philadelphia Health Management Corporation (PHMC) found that a significant portion of emergency room use is for non-urgent care.<sup>6</sup> The study found that 41.4 percent of the visits by Medicaid recipients and 37.5 percent of the visits by the uninsured to an emergency room were for non-urgent care, compared to 35 percent for the total population

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<sup>6</sup> A non-urgent condition is one that does not require treatment within 24 hours.



(PHMC 1986). This finding is similar to most other studies of hospital emergency room utilization.

The total amount of care provided at reduced or no charge is not known. Data are available on the amount of uncompensated care provided by hospitals and on the federal dollars that are spent on programs such as community health centers and maternal and child health programs to provide care to the uninsured. Information is limited on other sources, such as state and local contributions to public programs and the amount of discounted care provided by physicians. We return to these issues in our discussion of the health care financing system.

#### 4. The Cost of Closing the Access Gap for the Uninsured

While the uninsured face barriers in access to care, they do obtain a large amount of health care. Despite the lack of health insurance, the uninsured account for approximately 11 percent of all personal health care expenditures by non-institutionalized persons under the age of 65 (\$31.9 billion of the \$295 billion in total personal health care expenditures for non-institutionalized persons under the age of 65 (Figure 11)).

Nonetheless, while the uninsured consume a substantial amount of health care, per capita health spending for the uninsured is generally less than among the insured. On a per capita basis, health spending for the uninsured is only about 60 percent as great as among those with insurance (Table 10). Per capita spending by the uninsured was lower than among the insured for all types of health services including physician visits, and hospital inpatient and outpatient care.

Because the uninsured tend to be younger than the insured population we would expect that they consume less care than the insured population even without considering the impact of insurance on utilization. These shortfalls, however, as noted above, are not explained by age or health status.



Closing this gap in access is one of the prime motivations for seeking to extend insurance to the uninsured. It is important to note, however, that expanding health insurance coverage for the uninsured will not completely close the access gap. Some persons eligible for insurance may not enroll. Others eligible for public programs may be unable to enroll due to the complexity of the application process; those that do enroll may not be able to find providers to treat them. Even among those who do become insured, some may not seek care or may not seek care in an appropriate or timely fashion.

To develop an estimate of the extent to which the uninsured are forgoing health care and the cost of closing the access gap, this study estimated the level of health care utilization we would expect to find among the uninsured population if they were to become covered by insurance. This was accomplished by assuming that the utilization of health care services by uninsured persons would increase to the levels reported by insured persons with similar age, sex, income and health status characteristics. These estimates were developed using the Lewin/ICF Health Benefits Simulation Model (HBSM), in which the 1980 NMCUES data are adjusted to be representative of the population and health care expenditures in 1988. Thus, these estimates do not assume any efficiencies through the use of managed care mechanisms but do assume that this population would share in the reduction of hospital use that has occurred between 1980 and 1988.

The cost of closing the access gap is dependent on the services that would be covered by new insurance and the prices paid for those services. In this analysis it was assumed that the uninsured would become covered under a health plan covering physician care, hospital inpatient and outpatient care, and prescription drugs with a \$200 deductible and 20 percent coinsurance. The plan would not cover mental health care, dental care, and well-child care. It was assumed that utilization among the uninsured would increase only for those services covered under the plan. The cost of providing the services the uninsured do not receive under current policy was also estimated. Charges from new utilization were assumed to be the same on average as those charged

to insured persons for similar services. In developing these estimates, however, we used current charges for the current utilization by the uninsured were used. This is a conservative assumption because many of the uninsured are believed to receive services free of charge from providers for which they would be reimbursed if coverage were extended to the uninsured.

#### a. Utilization shortfall

The difference between the estimated level of utilization for the uninsured population once they become covered by insurance and the amount they currently use can be considered an estimate of the health care utilization shortfall attributed to the lack of health insurance. (This assumes that the current level of health care utilization by the insured is an appropriate benchmark. While this is a large assumption, no other baseline is available to measure the potential utilization shortfall against.) For example, as coverage is extended to the uninsured, the percentage of persons in this group with physician visits would increase by about 10 percent. The number of physicians visits for those who are uninsured under current policy would be over one-third higher which represents a shortfall of about 700 visits per 1,000 persons (Table 14).

Hospital utilization would also increase among those who are currently uninsured if they were to become covered under a health insurance plan. The number of hospital outpatient visits among those who are currently uninsured would increase by about 37 percent which implies an outpatient utilization shortfall of about 185 visits per 1,000 persons. Hospital inpatient admissions would increase by an estimated 46 percent which indicates a shortfall in inpatient admissions among the uninsured of about 40 admissions per 1,000 persons.

#### b. Increased expenditures associated with new utilization

Based upon the utilization response assumptions described above, we estimate that total health care expenditures for uninsured persons would increase by about one-third if health insurance coverage were extended to this

Table 14

## Estimated Utilization Shortfall for Uninsured Persons

	Current Policy	Utilization if Had Provided Insurance	Estimated Utilization Shortfall	Percentage Difference in Utilization
Percentage with physicians visits	52.5%	58.2%	6.0%	11.5%
Physicians visits per 1,000 persons	1,906	2,609	703	36.9%
Hospital inpatient admissions per 1,000 persons	91	133	42	46.3%
Hospital outpatient admissions per 1,000 persons	490	675	185	37.7%

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM) using the 1980 National Medical Care Utilization and Expenditures Survey (NMCUES) aged to depict 1988.



population (Table 15). Total expenditures for personal health care services for the uninsured would increase from about \$31.9 billion under current policy to about \$42.6 billion. This would be an increase in total health care spending of about \$10.7 billion. This can be interpreted as an estimate of the shortfall in health expenditures for uninsured persons.

The largest increases in health expenditures would be for physician and hospital care. Expenditures for physician care would increase by an estimated 39 percent. Hospital inpatient and outpatient care expenditures would increase by an estimated 42 percent. Expenditures for prescription drugs would also increase by about 28 percent. Overall, total personal health expenditures for the uninsured population would increase by about 34 percent over current expenditures.

The amount of the estimated health care shortfall is largely driven by the fact that the uninsured report themselves to be in poorer health status than do those with health insurance. Because insured persons reporting only fair to poor health tend to be higher volume users of health care, we estimate a rather large utilization response as coverage is extended to the uninsured. However, as this population receives needed care, their health status may improve and their utilization of health services may diminish over time.

#### E. FINANCING OF HEALTH CARE FOR THE INSURED AND UNINSURED

The discussion above has focused on the issue of uninsurance principally from the prospective of defining who the uninsured are the consequences for them of being uninsured. The focus is now shifted to the health care financing system to examine from what sources individuals obtain health insurance, why individuals are or are not insured, the extent to which alternative insurance programs result in underinsurance, how services are funded, and recent initiatives to expand access to insurance.

Health care is currently financed through out-of-pocket spending and a mix of public and private insurance, funding for direct services, and



Table 15

Estimated Induced Demand for Uninsured Persons Under "Typical" Insurance Coverage<sup>a/</sup>

	Uninsured Persons		
	Expenditures Under Current Policy (in billions)	Estimated Expenditures if Covered by Insurance (in billions)	Estimated Induced Demand (in billions) Current Policy
Hospital Inpatient Care	\$11.5	\$16.0	\$ 4.5 37.1%
Hospital Emergency Room and Outpatient Care	3.3	4.7	1.4 42.4
Physicians Office Visits	8.8	12.5	3.7 42.0
Other Professional	4.5	4.7	0.2 4.4
Prescription Drugs and Medical Sundries	2.5	3.2	0.7 28.0
Eyeglasses and Appliances	0.8	0.9	0.1 12.6
Other Health Care	<u>0.5</u>	<u>0.6</u>	<u>0.1</u> <u>20.0</u>
Total Health Care	\$31.9	\$42.6	\$10.7 33.5%

<sup>a/</sup> The estimated health care shortfall is the estimated increase in health expenditures which would result as insurance coverage is extended to persons who are uninsured under current law. This analysis assumes the health plan would cover hospital care, physicians care, and prescription drugs with a \$200 deductible and 20 percent coinsurance. The health plan would not cover dental care, mental health, or well-child care. No increase in utilization is estimated for noncovered services.

**Lewin/ICF**

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM) using the 1980 National Medical Care Utilization and Expenditures Survey (NMCUES) aged to depict 1988.

implicit subsidies. This section describes each of these financing sources, as a prelude to the discussion in the next section on how the limits in insurance influence who obtains coverage.

## 1. Insurance

The American health insurance system is based largely on private group health insurance for the employed and public sector coverage for the elderly and certain categories of the disabled and the poor, supplemented by other public and private insurance mechanisms, most notably non-group insurance.

Most Americans obtain their health coverage through an employer health plan. In 1987, 148.2 million persons were covered under an employer health plan (Table 16). About half of these persons (75.8 million) were workers covered on their own job while the remainder (72.4 million) were covered as dependents under a spouse or parent's plan.

In addition, about 31.7 million persons were covered under a non-group health plan, with some of these supplemental to Medicare or employment-based insurance. Overall about 75 percent of all Americans have health insurance through an employer health plan or a non-group health plan.

The largest public health insurance coverage program is Medicare. Approximately 30.4 million persons were covered by Medicare during 1987 (Table 16). Of these, 27.5 million were aged persons and about 2.9 million were disabled persons under the age of 65. The second largest public health plan is Medicaid which covered an estimated 20.7 million persons in 1987. In addition, about 10.5 million persons were covered as dependents under CHAMPUS or other military health insurance programs.

Overall, about 86.8 percent of the civilian population has health coverage from at least one source. Many individuals have coverage from two or more sources. For example, of those who are enrolled in Medicare, about 11.7

Table 16

## Distribution of Persons by Source of Insurance Coverage in 1987

	Number (in millions) <sup>a/</sup>	Percent of Total Population
All Persons	241.1	100.0%
All Insured	209.3	86.8
Medicare	30.4	12.6
Medicaid	20.7	8.6
CHAMPUS or Military	10.5	4.4
Employer Group Coverage	148.2	61.4
Covered on own job	75.8	31.4
Covered as dependent	72.4	30.0
Nongroup Coverage	31.7	13.1
All Uninsured	31.8	13.2%

Numbers do not add to total population because some persons are covered by more than one insurer.

Source: Preliminary estimates from the March 1988 Current Population Survey data, June 30, 1989. Subject to revision.

million have supplemental coverage under a non-group plan and about 6.2 million have coverage under an employer plan. Also, about 3.3 million Medicare enrollees are also covered under the Medicaid program.

The major types of insurance are described below: employment-based insurance, Medicare, Medicaid, state-sponsored health programs, and non-group insurance.

#### a. Employment-based insurance

Employer health insurance plans are the largest source of health coverage for persons under the age of 65. Employer plans covered 148.2 million workers and dependents under the age of 65 and paid an estimated \$118 billion in health benefits for nonelderly persons. Overall, employer health plans covered about 61 percent of all non-elderly Americans and pay for over 40 percent of total personal health care expenditures for this population (Figure 11).

Obtaining employment-based insurance involves separate decisions by employers and employees. The employer must decide whether or not to offer coverage, the types of benefits to offer, and whether and how much to contribute to the premium. Employees must decide whether to accept employer-based coverage for themselves and for their dependents. The next section describes why some employers do not offer coverage and why some employees do not accept it.

Large and small employers face different markets for health insurance. Large groups may self insure, and whether they do or not, a substantial portion of their premium will be based on the experience of the group itself. The group can also keep administrative costs low by assuming responsibility a significant portion of the administrative burden of enrolling and disenrolling beneficiaries, and explaining coverage to employees. The market for this insurance is competitive and administrative costs borne by the companies are low.



The market for small employers is more restricted and more costly. Because of their size, small groups do not reflect the broad or normal distribution of risk of large groups. Insurers thus pool the experience of small groups and seek to avoid groups that are likely to have higher than average claims. This may be accomplished by not offering insurance to very small employers, or employers in certain industries. In small groups, insurers may do medical underwriting, i.e., require individual health histories. Insurers attempt to screen out bad risks, and may not opt insure selected members of the group or not insure the group as a whole. This is partly because insurers are concerned that adverse selection will occur, making the small group more costly to them. While these mechanisms can create a low-risk group initially, with low health care use, over time the health care use of the group will move toward the average.

Premiums for small groups are often high compared with those of large groups for comparable coverage. This reflects the higher administrative expense of servicing small groups and the addition to the premium of a factor for increased risk associated with the lack of experience rating for the individual group. As a result, private insurers generally include in small group premiums a higher administrative surcharge ranging from 12 to 25 percent of benefit payments to cover the greater risk associated with insuring a small group. This reflects the belief that small groups present a greater loss risk relative to total premium payments than do larger groups. For example, in some small groups, a single catastrophic illness may cost more than total group premium payments. This risk factor accounts for the large administrative overhead charges assessed on small groups. In addition, there is a perception among insurers that persons in small groups who are most likely to purchase insurance are those in poor health status and in greater need of insurance.

A number of efforts have been made to reduce the cost of insurance to small firms. One of the most commonly discussed is pooling the experience of separate small firms into larger groups for purchasing health insurance.

Through such groups employers hope to reduce the administrative costs and risk premium associated with coverage for small groups. Several models have been discussed, including Multiple Employer Trusts, self-insuring pools, and affinity groups, with coverage provided by insurance companies. However, concern about adverse selection remains even if many small groups pool into larger ones because these could still be unhealthy small groups.

#### **b. Medicare**

Medicare provides coverage to over 30 million elderly, blind, and disabled persons. The program has two components that pay for different types of services and are financed through different sources of funds. Part A, the Hospital Insurance program, provides inpatient hospital coverage, limited home care and skilled nursing facility benefits. Part B, the Supplementary Medical Insurance program, covers the costs of most physician services, laboratory tests, and outpatient hospital care. Part A coverage is extended automatically to those 65 years of age who receive Social Security. Part B coverage is optional and requires a monthly premium payment, along with an annual deductible and a 20 percent coinsurance payment rate for most services. Purchase of Part B is usually made by the individual, but it can also be made by the state through a buy-in agreement, where the state uses the Medicaid program to pay the Medicare Part B premium on behalf of the Medicaid recipient. The effect of the buy-in is that Medicare becomes responsible for financing services under its usual coverage and reimbursement rules while the Medicaid program becomes responsible for beneficiary cost-sharing amounts.

The number of elderly with Part B coverage has risen steadily over the years. In 1987, 88 percent of the aged with Part B coverage purchased it directly. Another 8 percent of the elderly had Part B coverage purchased for them by a state buy-in program, leaving only 4 percent of the elderly receiving Part A coverage not enrolled in Medicare Part B.

Based on data from household interviews conducted in 1986, a large percentage of the elderly purchase private health insurance to supplement the

coverage offered by Medicare, commonly referred to as Medigap insurance. The survey found that almost 72 percent of those individuals over the age of 65 had both Medicare and private insurance, approximately 18 percent had only Medicare coverage, and about 6 percent had a combination of Medicare and Medicaid. The remaining 4 percent reported having no insurance, or they had a wide variety of coverages that included CHAMPUS and other public plans.

The disabled under age 65 who are receiving monthly Social Security Disability Insurance (SSDI) benefits may also receive Part A benefits, and elect Part B. However, the disabled face restrictions on Medicare eligibility. Disabled persons under age 18 are not eligible for Medicare even when their parents have contributed to Social Security, except in cases of chronic kidney disease. Adults aged 18-64 can become eligible for Medicare if they become disabled after they have contributed to the Social Security system (or if they are dependents of Social Security beneficiaries who are retired, disabled, or deceased) for a certain period (which varies by age) (Griss 1989). Disabled persons must wait an initial five months before SSDI benefits commence, which is followed by a 24-month waiting period before they become eligible for Medicare coverage.

A number of gaps remain in Medicare coverage. The program does not cover outpatient prescription drugs, most forms of preventive care, and has limits on hospital and physician services. In addition, as noted above, disabled persons on SSDI must wait 24 months before becoming eligible for Medicare. This 24-month waiting period is a major access issue for the low-income disabled. The number of beneficiaries who go without health insurance coverage during this 24-month period is significant. A study on eliminating the waiting period reports that 27 percent of SSDI recipients had no insurance coverage during months 18-24 of the waiting period (Bye and Riley, 1989). The waiting period poses significant problems for persons with AIDS who are not likely to survive the two-year waiting period.

The Medicare Catastrophic Act of 1988 would have closed some of these gaps in Medicare coverage. It would have expanded hospital and



physician benefits under the program and created a new outpatient drug benefit. However, Congress repealed these Medicare expansions in The Omnibus Reconciliation Act of 1989 (OBRA, 1989).

One important provision of the Catastrophic Coverage Act was retained, however. This would require state Medicaid programs to pay the Medicare premiums, copayments and deductibles of the Medicare program and the catastrophic insurance portion for Medicare beneficiaries below poverty. This is a substantial expansion beyond the optional purchase of Part B for those qualifying for Medicaid through SSI or 209(b) standards. Regardless of the mandate, states have an incentive to obtain Part B coverage for all Medicaid beneficiaries who could qualify for it because the federal government will not match state Medicaid payments for services which could have been covered by Medicare.

#### c. Medicaid

The Medicaid program is a jointly funded federal-state program that pays for medical services for certain groups of low-income persons. Each state designs and administers its own Medicaid program within broad federal guidelines and requirements. As a result, there is substantial variation among the states in terms of persons covered and benefits offered. All states with the exception of Arizona, which is operating an alternative demonstration program, have Medicaid programs.

Eligibility for Medicaid is complex. It is determined by two factors: categorical requirements and income standards. Assets also determine eligibility. The basic category of eligibility for Medicaid is eligibility for cash assistance. Categorical requirements are the family composition or demographic characteristics. Thus, elderly and disabled persons can obtain Medicaid, as can pregnant women, children, and other members of



families where there is a single or unemployed parent.<sup>7</sup> Coverage for some groups is mandatory for the state; coverage of other groups is a state option. Some persons may meet the income standards for Medicaid, but not the categorical requirements. Among those who may not be categorically eligible for Medicaid (unless they can establish themselves as disabled and SSI-eligible) are homeless single males, some of whom may be substance abusers and at high risk of contracting AIDS.

Until recently, eligibility for Medicaid was largely linked to eligibility for cash assistance, including the Aid to Families with Dependent Children (AFDC) and Aid to the Aged, Blind, and Disabled programs (now SSI). Successive changes in federal law, beginning with the Omnibus Reconciliation Act of 1986 (OBRA86), have changed this. There are now several groups, many of them optional to the states, that can obtain Medicaid coverage without being eligible for cash assistance. This allows states to provide additional medical coverage without increasing state expense for cash assistance. For example, the Medicare Catastrophic Act required coverage for pregnant women and young children and the elderly and disabled with incomes below the poverty level. More recently with OBRA 1989 Congress mandated coverage for pregnant women and young children with incomes below 133-1/3 percent of poverty. The new groups, with the exception of the elderly disabled, are primarily working poor populations who have incomes too high to qualify for AFDC or Medicaid under the traditional income thresholds.

Medicaid has emerged as an important source of coverage for persons with AIDS. Current estimates indicate that approximately 40 percent of all AIDS patients become eligible for Medicaid at some point in the course of their illness. While Medicaid covers a large proportion of the AIDS patients, the program's share of the total costs of treating AIDS is estimated to be 20 to 30 percent, with private insurance financing 40 to 60 percent of the costs

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<sup>7</sup> "Unemployed" carries a specific definition in the AFDC "Unemployed parent" program, including requirements on previous work history and a provision that the breadwinner be working no more than 100 hours per month. Thus some part-time workers can be included in this category.

(OTA, 1987). Medicaid's role in financing health care for persons with AIDS is likely to expand in the future. Estimates suggest that AIDS is likely to absorb about 5 percent of the Medicaid budget in the 1990s, with some states experiencing increases of 10 to 15 percent in AIDS-related Medicaid expenditure (Pascal, 1987). These projected increases may be the result of the number of low-income AIDS patients who are IV drug users, new forms of treatment that are extending the life of AIDS patients, and decreases in other forms of insurance.

Some of those insured by Medicaid may be underinsured. Medicaid is commonly perceived as a comprehensive coverage program. However, states have the flexibility to establish a number of limitations on the amount, duration, and scope of care provided through their Medicaid programs. Although the program mandates certain basic services and compliance with federal limits on these services, states vary with regard to the additional restrictions, if any, they apply to basic service provisions. Eleven states limit the number of reimbursable hospital days on an annual basis or on a per-admission or spell-of-illness basis. Other states require prior authorization for stays extending beyond 15 and 18 days. Eleven states also limit the number of hospital outpatient visits during a year (US DHHS, HCFA, 1987). States may also limit the frequency of physician visits for specific settings; limits to visits to long-term care facility recipients ranging from 2 to 36 per year per recipient have been imposed in 12 states (US DHHS, HCFA, 1987).

States vary considerably in the optional services they provide and in the limitations on those services. While all but two states provide prescription drugs to Medicaid recipients, 12 states place limits on the number or cost of prescriptions that can be filled over a certain time period, usually per month (US DHHS, HCFA, 1987). Many states also limit or do not cover clinic services, personal services in a recipient's home, or optional mental health and substance abuse services.

In addition to these specific limits on basic Medicaid services, there is the less explicit restriction that results from low provider

reimbursement rates (Thorpe, 1989), paperwork, and payment delays. Providers are often reluctant to treat Medicaid recipients; it has been reported that over 25 percent of private practice physicians refuse to participate in Medicaid (US DHHS, HCFA, 1987). Limited provider participation can act as an effective constraint on Medicaid recipients' access to health care.

#### d. State-sponsored health programs

In addition to Medicaid, some states also sponsor a number of other health care programs. One type of state-sponsored health care program is General Assistance Medical Care (GAMC). These programs are usually tied to state or locally supported general assistance cash benefit programs that have guidelines similar to (and sometimes stricter than) those for AFDC or SSI. Program benefits are usually less generous than Medicaid benefits and are targeted to single adults and childless couples.

In 1987, 22 states reported having GA-Medical programs; in 19 of those states a recipient of GA cash assistance was automatically eligible for GA-medical assistance. Four of the states (Massachusetts, Michigan, Vermont, and Virginia) cover only non-hospital services, with the remaining 18 states (Alaska, Connecticut, Hawaii, Illinois, Kansas, Maine, Maryland, Minnesota, Missouri, Montana, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Washington, and Wisconsin) largely offering the same services as those covered by Medicaid.

A second type of state-sponsored health care programs is state indigent care programs that are not related to other general assistance or income programs. Often administered and financed in conjunction with county governments, the programs aim to provide access to medical care for low-income individuals who do not qualify for Medicaid. While the states have taken a wide variety of approaches, a few examples include programs that provide either state-funded medical coverage or premium subsidies for the first year a former welfare recipient is employed in a low-income job (Delaware, Iowa, Massachusetts, Maine, Washington, Wisconsin), and programs that pay for



preventive services in relation to specific diseases such as breast cancer (Colorado). Some states establish broad guidelines or standards, provide earmarked funds, and/or allow each county to collect its own revenues expressly to cover indigent health care costs, and then allow the counties to distribute the funds as they best see fit (California, Florida, Minnesota, Nevada, Texas). In 1988, approximately 17 states had some version of a state-wide indigent care program.

#### e. Non-group coverage

Non-group insurance coverage is available to many individuals and their families who do not have access to group insurance or a public source of insurance. These plans can be relatively expensive and often include medical underwriting to exclude persons with certain medical conditions from coverage. Non-group insurance is sometimes purchased as a supplement to Medicare or a limited employment-based policy. Its purchase involves an active decision by an individual or family, who frequently pays the whole cost single-handedly. Coverage is usually more costly and less comprehensive than group policies.

Despite its high cost, a large number of people purchase non-group coverage. This includes many low-income persons (Table 17). Approximately 8.6 percent of the population under age 65, or 18.3 million people, have only non-group coverage. This number is over one-half the size of the total uninsured population. Without this coverage, many of these people might be uninsured.

Also important to note is the wide income distribution of persons who purchase this coverage. Among those in the upper income brackets, nearly 7.5 percent have non-group coverage. A higher proportion, almost 10 percent, of persons with incomes below \$10,000 have non-group insurance. The large number of low income individuals who purchase this coverage is striking, given its expense. Equally striking is the large number of higher income individuals not receiving coverage through employment or Medicare who do not purchase such coverage. Among those with incomes over \$30,000 without group



Table 17

Comparison of Uninsured to Persons with Non-Group Coverage by Income  
Persons Under Age 65  
(In thousands)

	Total Persons	Uninsured Percent	Non-Group Percent	by Other Insurance Percent
Total	212,628	14.8	8.6	76.6
\$0 - 10,000	29,258	32.8	9.8	57.4
\$10,000 - 20,000	36,642	26.8	10.1	63.1
\$20,000 - 30,000	36,642	13.7	9.1	77.2
\$30,000+	110,719	6.6	7.5	85.9

Source: Preliminary estimates from the March 1988 Current Population Survey data. Subject to revision. July 1, 1989.

coverage or Medicare, 47 percent are uninsured, while only 53 percent have nongroup coverage. It is unclear whether this is a matter of personal decision, lack of availability of insurance due to medical underwriting, or perceived unaffordability of such coverage.

## 2. Directly Financed Services

Much of the health care for the uninsured and underinsured is financed by grants or appropriations directly to providers, although the same providers may also be reimbursed by insurance as well. The sources of financing for these services vary by the type of service:

- **Hospital services.** In considering direct financing of hospitals it is useful to distinguish between public and private hospitals. Public hospitals provide a large amount of care to the uninsured and underinsured. They are an especially important source of care for those with severe mental illness. Public hospitals often receive direct funding from state and local governments to meet their operating losses. In some communities private hospitals may also receive direct payments to underwrite their operations and assure access to care. Current estimates suggest that public hospitals assume about 15 percent of the costs of treating AIDS patients (Andrulis, 1987). In addition, both public and private hospitals may receive contracts to provide certain services to the poor under such programs as the Maternal and Child Health Block Grant. While public funds are the principal source of direct funding for hospital services, philanthropy may also play a role. Many hospitals conduct fund raising drives to support charity care, and some hospitals, such as the Shriners Hospital for Crippled Children, are completely dependent on philanthropy.
- **Physician services.** Federal, state, and local governments finance a number of organized primary care centers that provide services to the uninsured. The federal Community and Migrant Health Center program provides \$460 million to fund about 600 centers serving 5 million people. In addition, state and local governments fund public health clinics to provide care to low-income persons. Some communities have categorical clinics -- well-child care, TB, sexually transmitted diseases, etc. -- with a limited scope of services. In others, general physician services are provided. Community health centers and public health clinics may also receive contracts from a variety of sources to provide services to specific populations, such as women and children or the homeless. Such funding sources include the MCH Block Grant, the WIC program, and the McKinney Act for the homeless.

- **Prescription drugs.** Access to prescription drugs is a problem for many of the uninsured, particularly those with chronic conditions, such as diabetes and hypertension. Seven states (DE, IL, ME, MD, NY, NJ, PA) have Pharmacy Assistance Programs to subsidize the cost of prescription drugs to certain low-income populations. These programs are usually targeted to the elderly, but the Maryland program includes all low-income persons. Organized primary care centers and physicians often rely on donations and samples from pharmaceutical companies to provide drugs to the uninsured. In addition, some pharmaceutical companies donate prescription drugs to providers for use by low-income persons.
- **Other services.** Some federal and state money is also available for other services needed by low-income persons, such as transportation, nutrition counseling, and other support services. These funds are usually directed to organized primary care centers, such as hospital outpatient departments and community health centers.

Government is a principal source of funds for direct services. For 1987, HCFA estimates that federal-, state-, and local-financed programs for personal health services other than Medicaid and Medicare paid \$45 billion in health care (Table 18). This represented over 10 percent of personal health care expenditures (Letsch, Levin, and Waldo, 1988).

Because of how HCFA's National Health Accounts are structured, additional expenditures for personal health services are included in the expenditures for public health activities of state and local health departments. The precise amount of these funds cannot be determined. The Public Health Foundation of ASTHO, however, estimates that of the \$8.1 billion spent in FY1987 by state health agencies, \$3.2 billion was spent on personal health programs, exclusive of maternal and child health (which is included by HCFA in the personal health expenditures account). While the ASTHO and HCFA figures are not directly comparable, these figures strongly suggest that federal, state, and local expenditures for personal health services constitute at least 11 percent of personal health spending.

Between 1980 and 1987, public funds for these services have grown more slowly than health spending in general (Table 19). Total personal health expenditures grew at a rate of 10.5 percent per year. Federal spending



Table 18

Government Expenditures for Personal Health Care and Public Health  
Activities by Selected Source of Funds and Type of Expenditures, 1987<sup>a/b/</sup>  
(Billions of Dollars)

	Government Expenditures Excluding Medicaid and Medicare			Total Expenditures	Total National Expenditures
	Federal	State and Local	Total		
<b>Personal Health Services</b>					
Hospital Care	17.0	14.1	31.1	102.2	194.7
Physicians' Services	1.0	4.1	5.1	31.8	102.7
Dentists' Services	0.0	0.1	0.1	0.7	32.8
Other Professional Services	0.1	0.3	0.4	5.4	16.2
Drugs and Sundries	0.2	0.4	0.5	3.9	34.0
Eyeglasses and Appliances	0.1	0.2	0.3	2.1	9.5
Nursing Home Care	0.9	0.6	1.5	19.9	40.6
Other Personal Care	4.0	1.7	5.7	9.4	12.0
Total	23.2	21.5	44.7	175.3	442.6
<b>Public Health Activities</b>	1.6	13.1	14.7	14.7	14.7

Note: 0.0 denotes less than \$50 million.

<sup>a/</sup>Government expenditures for personal health care include such programs as the Veterans' Administration, Department of Defense, Indian Health Service, worker's compensation, maternal and child health, and community health centers; at the state and local level, included are temporary disability, worker's compensation, G.A. (that which is separate from Medicaid), maternal and child health, vocational rehabilitation, medical payment, school health programs, and state and local hospital spending (i.e., expenditures to help cover charity care).

<sup>b/</sup>Public Health Activities include such programs as the center for Disease Control (federal) and the activities of state and local health departments including direct service provision.

Source: Suzanne W. Letsch, Katharine R. Levit, and Daniel R. Waldo, "National Health Expenditures, 1987," Health Care Financing Review, Winter 1988.



Table 19

Personal Health Care Expenditures and Federal and State  
Non-Medicare and Non-Medicaid Expenditures, 1980 and 1987

	1980	1987	Average Annual Change
Personal Health Expenditures			
Total	219.7	442.6	10.5%
Federal Other	13.1	18.8	5.3%
State and Local Other	12.4	18.1	5.6%
State and Local Public Health	6.0	13.1	11.8%
Federal Other and State/Local Non-Medicaid	31.5	50.0	6.8%

Source: Letsch, Levit and Waldo, "National Health Expenditures," 1987.

other than Medicare and Medicaid grew at a rate of 5.3 percent per year; state spending other than Medicaid grew at a rate of 5.6 percent. If all state and local public health spending is added to these accounts, the overall growth was 6.8 percent per year. As noted earlier, in the 1980 to 1987 period, the number of uninsured grew by approximately 30 percent, suggesting that public funds to meet the additional needs of the newly uninsured lagged behind the increase in their numbers.

In addition to public spending, private philanthropy can also support these services. HCFA estimates that in 1987, other private sources of payment amounted to \$2.2 billion for hospital care, \$200 million for physician services and other professional services, and \$300 million for nursing home care.

### 3. Implicit Subsidies and Cost Shift

In addition to support through public funding and philanthropy, charity care by hospitals and other providers traditionally has been financed through cross-subsidies from privately insured patients. Hospitals in particular have charged more to insured patients to help finance unpaid bills. Estimates of total charity care are not available, but the cost of uncompensated care<sup>8</sup> (charity care and bad debt) provided by hospitals in 1989 was estimated at \$9.6 billion.

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<sup>8</sup> Uncompensated care includes charity care, services for which individuals could not be expected to pay, and bad debt, care for which payment was expected. Historically, hospitals have not clearly differentiated between these, and indeed drawing fine distinctions has proven difficult. Both figures are usually included together and except for careful prospective studies with clear criteria, allocations between the two accounts are suspect. Uncompensated care may be stated in terms of the charges billed but unpaid, or the costs associated with that care, which we believe better reflects the resources required to furnish the care. In the past, hospitals have stated uncompensated care spending in terms of charges, but recent analysis have begun presenting cost estimates.

Uncompensated care appears to involve a bimodal distribution of services. A large proportion of such care is due to many small bills, especially for emergency room and outpatient services (Health Policy Institute, 1988). Another large portion of this uncompensated care is for high-cost illness. In a sample of hospitals in Florida, for example, only 2 percent of all patients with unpaid bills had expenses of \$10,000 or more, but their bills accounted for 32 percent of all uncompensated care (Lewin and Associates and the Center for Health Policy Research, University of Florida, 1986). Understanding these patterns will help in estimating how each option (e.g., catastrophic coverage) would impact on charity care, and the extent to which it would preserve this system of cross-subsidies or requires its replacement.

The extent of the burden that uncompensated care imposes upon hospitals is unclear. Hospitals have argued that eroding margins make such care more difficult to provide, and that having to increase charges to cover large amounts of uncompensated care puts hospitals at a competitive disadvantage. Such arguments appear reasonable, but analyses of hospital margins and charity care loads or pricing margins needed to cover uncompensated care expenses show no correlation between charity care and margin (Lewin/ICF, June 1988).

More is known about the charity care provided by hospitals than other providers. Evidence exists that some physicians do reduce their charges for uninsured, low-income patients. Surveys suggest the charity loads may be as high as 10 percent in some communities. The survey data must be used with caution, however, as response rates were low and the data were estimates provided by physicians and their office staff. Moreover, most hospitals have systems for assigning uninsured patients without a regular physician to staff physicians or medical staff members for treatment if a patient is admitted through the emergency room. Often, these physicians provide follow-up care. Physicians in several states have helped organize formal systems for referring uninsured patients to community physicians for care at no cost (Lewin/ICF, March 1988; American Medical News, September 26, 1988).

## F. WHY THE UNINSURED AND UNDERINSURED LACK COVERAGE

Why do approximately 32 million Americans lack any form of public or private health coverage and many million more have inadequate coverage? For some, particularly the working poor, insurance is often not available through their employers, and the cost of purchasing a non-group insurance plan is prohibitive. For many of the poor, eligibility limitations and enrollment inefficiencies prevent access to public insurance programs. For some higher income uninsured, lack of coverage may be a matter of personal choice, or lack of access to insurance due to their health status. We have identified five factors that play substantial roles in determining who is insured.

### 1. Many Employers Do not Offer Health Benefits

Many employers, particularly small employers, do not offer health benefits. A study conducted by Lewin/ICF for the Small Business Administration found that 44 percent of all firms do not offer health benefits. The study showed that the percentage of firms that do not offer health benefits ranges from about 54 percent for firms with 10 or fewer employees to about 2 percent for those with 100-499 employees (Table 20). These findings are consistent with other employer surveys conducted at the state and local level. For example, surveys of small employers in Pennsylvania, Denver, Wisconsin, and Fairfax County, Virginia, found that between 42 and 62 percent of firms with fewer than 5 employees and between 16 and 40 percent of firms with between 5 and 10 employees do not offer insurance.

Workers without employer health insurance can be found in all industries and among workers of all wage levels. However, workers without employer health coverage tend to be private sector workers in smaller firms. Lower wage and part-time employees are also more likely to be without employer health insurance than are other workers. The percentage of workers without employer health insurance tends to be greatest among the agriculture, services, construction, and retail trade industries.



Table 20

## Percentage of Firms That Offer Health Coverage By Firm Size

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Number of Employees	Percentage of Firms That Do Not Offer Health Coverage
1 - 9	54%
10 - 24	22
25 - 99	8
100 - 499	2
500+	<u>0</u>
Total All Firms	44%

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Source: Lewin/ICF analysis of SBA, Office of Advocacy, Health Benefits Data Base, 1986.

a. Characteristics of workers who lack employer coverage

Workers who do not have coverage through their own employers<sup>9</sup> tend to be lower wage workers. Of the 28.5 million workers who do not have employer health insurance, over one-third had average weekly earnings of less than \$150. About one-half percent of all workers with less than \$150 in weekly earnings did not have employer health insurance. The percentage of workers without employer health insurance declined as weekly earnings increased to about 10 percent among workers with weekly earnings of \$600 or more (Table 21).

Part-time workers are more likely to be without employer health coverage than are those who work full-time (32.1 percent compared to 20.7 percent). Nearly two-thirds of workers without employer health insurance, however, are full-time workers (Table 21).

Part-time workers were more likely to have obtained their employer coverage as a dependent on their spouse or parent's plan than were full-time workers. About 36 percent of all part-time workers who were covered under an employer plan were covered as the dependent under a spouse or parent's plan. By comparison, only about 12 percent of all full-time workers covered by an employer plan obtained this coverage as a dependent.

b. Characteristics of employers who do not offer coverage

Most workers who were without employer health insurance were either employed in the private sector or self employed. Over two-thirds of all workers without employer health insurance coverage were employed in the

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<sup>9</sup> This analysis focuses on workers without employer-provided health insurance. Not all these workers are uninsured, however. They may obtain coverage from their spouses, by purchasing non-group policies, or through public programs such as Medicaid. While we concentrate on the presence or absence of employer coverage, we also identify the extent to which employees are insured through other sources.

Table 21

Working Persons Not Covered from Own Job  
By Average Weekly Earnings and Full-Time/Part-Time Employment Status<sup>a/</sup>

	Without Employer Coverage (in millions)	Percent of All Not Covered	Percent of Workers in Group Not Covered
All Persons	28.5	100.0%	23.7%
Average Weekly Earnings			
Self-employment Loss	0.2		
\$ 1-149	9.9	0.9	49.3
\$150-249	7.3	34.7	50.6
\$250-399	5.6	25.7	36.0
\$400-599	3.0	19.5	19.6
\$600-799	1.2	10.6	12.2
\$800+	1.3	4.1	9.5
		4.5	10.9
Full-Time/Part-Time Status of Worker			
All Workers	28.5	100.0%	23.7
Full-Time (>35 hours)	18.4	64.6	20.7
Part-Time (<=35 hours)	10.1	35.4	32.1
1-20 hours	4.6	16.1	26.1
21-35 hours	5.5	19.3	39.7

<sup>a/</sup> Includes persons employed sometime during 1987 age 18 and older.

Source: Preliminary estimates from March 1988 Current Population Survey data. Subject to revision. July 1, 1989.

private sector while about 22 percent were self employed (Table 22). About 9 percent of all workers without employer coverage were employees of federal, state, or local governments.

About one-half of all self-employed persons did not have employer coverage. Self-employed persons who were unincorporated were about twice as likely to be without employer health coverage as were incorporated self-employed persons (Table 22).

The lack of employer coverage among self-employed persons can be attributed to the high cost of insurance for these individuals. They must pay for insurance at individual or small group rates and must pay the full amount of the premium without an "employer" contribution. When non-group coverage is considered, the proportion of self-employed persons without some form of private insurance (group or non-group) is substantially reduced.

Over one-half of all workers who do not have employer health insurance are employed in small firms. Of the 28.5 million workers without employer health insurance, about 15.5 million (54 percent) were in firms with fewer than 25 employees. In fact, about 44 percent of all workers employed in firms with 25 or fewer employees were without employer health insurance. The percentage of workers without employer health insurance drops to about 24 percent among firms with 25 to 99 employees and declines to about 12 percent among firms with 1,000 or more employees (Table 22).

The percentage of workers without employer health insurance varies significantly by industry. The percentage of workers without employer health insurance ranged from a high of 63 percent in the agriculture, forestry, and fishing industries to a low of about 12 percent in the durable goods manufacturing industries. About 48 percent of workers in the personal services industry were without employer health coverage while between 35 and 39 percent of workers were without employer coverage in the construction, retail trade, and services industries (Table 23).



Table 22

Working Persons Without Employer Coverage  
By Class of Worker and Size of Firm<sup>a/</sup>

	Without Employer Coverage (in millions)	Percent of All Not Covered	Percent of Workers in Group Not Covered
All Persons	28.5	100.0%	23.7%
Class of Worker			
Private	19.7	69.1	23.2
Government	2.7	9.4	14.7
Federal	0.7	2.4	17.7
State	0.7	2.5	15.2
Local	1.3	4.7	13.3
Self-employed	6.2	21.5	48.4
Incorporated	0.9	3.3	26.4
Unincorporated	5.2	18.2	56.1
Number of Employees in Firm			
1-24	15.5	54.1	44.2
25-99	3.9	13.7	24.4
100-499	2.9	10.3	16.6
500-999	0.8	3.0	12.6
1,000 or more	5.4	18.9	11.8

<sup>a/</sup> Includes persons employed sometime during 1987 age 18 and older.

Source: Preliminary estimates from March 1988 Current Population Survey data. Subject to revision. July 1, 1989.

Table 23

Percentage of Workers Without Employer Coverage by Industry<sup>a/</sup>

Industry	Percentage of Workers Without Employer Coverage
Agriculture/Forestry/Fishing	63.4%
Mining	14.0
Construction	36.7
Durable Goods Manufacturing	11.8
Non-durable Goods Manufacturing	16.3
Transportation/Communications	15.8
Wholesale Trade	19.2
Retail Trade	35.6
Finance/Insurance/Real Estate	18.1
Business and Repair Services	34.7
Personal Services	47.7
Entertainment/Recreation	38.9
Professional Services	18.8
Public Administration	12.3
Total Persons	23.7%

<sup>a/</sup> Includes all persons employed sometime during 1987 age 18 and older.

Source: Preliminary estimates from March 1988 Current Population Survey data.  
Subject to revision. July 1, 1989.

### c. Employer coverage of dependents

About 114 million Americans were employed sometime during 1987. Of these, about 61 percent (69 million) were covered by an employer health plan on their job. Of the 25 million workers who do not have employer coverage on their own job, over one-third (16 million) were covered as dependents on a spouse or parents employer plan, while almost two-thirds are without any form of employer coverage.

Most of the 16 million workers covered under a spouse's plan are spouses in two worker families where one spouse has employer coverage on his or her job while the other does not. In some instances, however, the dependent spouse may have been eligible to participate in his or her own employer's health plan but chose not to do so. This may occur because the employee contribution for family coverage on the spouses plan is lower than the contribution required for coverage on his or her own job. It may also occur in cases where one spouse's plan is perceived to offer better benefits than does the other. The issue of whether or not working spouses should be required to accept insurance from their own employer is an area of much debate around options to extend employer-based insurance.

Employer plans cover 56 million nonworking dependent spouses and dependent children. This includes 13 million spouses (of 19 million) and 43 million dependent children (of 58 million) (Table 24).

About 49 million workers and their nonworking dependents do not have employer coverage. These include 28.5 million employed persons and 20.9 million nonworking dependent spouses and children. These dependents are an important group because both the workers and their dependents could potentially be affected by efforts to expand employer health insurance coverage.

Most uninsured nonworking spouses and children are dependents of a full-time worker. While about 35 percent of workers without employer coverage

Table 24

## Workers and Non-working Dependents by Employer Coverage Status in 1987

	All Workers a/		Non-working		Dependent Children	
	Number (in millions)	Percent	Number (in millions)	Percent	Number (in millions)	Percent
Covered on own job	68.8	60.5%	--	--	--	--
Covered as Dependent on Spouse or Parent's Employer Plan	16.4	14.4	13.1	69.3	42.7	73.9
Not Covered on Employer Plan	28.5	25.1	5.8	30.7	15.1	26.1
Total	113.7	100.0%	18.9	100.0%	57.8	100.0%

a/ Includes persons employed sometime during 1987 age 18 or older.

Source: Preliminary estimates from the March 1988 Current Population Survey (CPS) data. Subject to revision. July 1, 1989.



are part-time workers, about 74 percent of nonworking spouses and children without employer coverage are dependents of full-time employees (Table 25).

Nonworking dependents of uninsured workers are slightly more concentrated among larger employers than are workers without employer coverage. However, about one-half of all dependents of workers without employer health insurance were in firms with under 25 employees.

Uninsured workers and their dependents tend to be concentrated among the retail trade, construction, and professional services industries. About 20 percent of all uninsured workers and their dependents are in the retail trade industry. About 17 percent of these persons are in the professional services industries and about 11 percent are in construction (Table 26).

#### d. Reasons employers do not offer coverage

A number of the proposed options to expand insurance are designed to encourage small employers to provide coverage. In considering the feasibility of those options, it is important to consider the reasons these firms do not offer coverage. The Lewin/ICF SBA survey found that the most commonly cited reason was insufficient profits (67 percent) with the high cost of insurance the second most common reason (62 percent) (Table 27). About 19 percent cited job turnover among the work force as a primary reason while 16 percent indicated that group insurance was unavailable. While other reasons were reported, the survey clearly indicated that high cost or affordability were the primary obstacles to offering coverage. An employer survey in Denver found that in tight job markets, employers who can hire without offering benefits will do so, especially if the benefits are not traditional in the area. These results and those of other employer surveys confirm that the most common barrier to employers in providing insurance is affordability.

Small firms face higher costs for providing insurance coverage than larger firms. As discussed earlier, this reflects higher administrative costs associated with servicing small groups and the addition to the premium of a

Table 25

Working Persons and Dependents Not Covered By Employer Insurance  
By Employment Status and Firm Size

Class of Workers	Workers and		Non-Working Dependents	
	Dependents Without Employer Coverage	Workers Without Employer Coverage <sup>a/</sup>	of Workers Without Coverage on Job	
Part-Time/Full-Time Status of Worker				
Full-Time (> 35 hours)	68.6%	64.6%	74.0%	
Part-Time (<= 35 hours)	31.4	35.4	26.0	
1-20 hours	14.6	16.1	12.5	
21-35 hours	16.8	19.3	13.5	
Number of Employees in Firm of Worker				
1-24	52.9%	54.1%	51.0%	
25-99	13.8	13.7	13.9	
100-499	11.0	10.3	12.0	
500-999	3.2	3.0	3.9	
1,000 or more	19.1	18.9	19.2	
Total Persons	100.0%	100.0%	100.0%	
Number (millions)	49.3	28.5	20.8	

<sup>a/</sup> Includes persons employed sometime during 1987 age 18 and older.

Source: Preliminary estimates from March 1988 Current Population Survey data. Subject to revision. July 1, 1989.

Table 26

Number and Percentage of Working Persons and Non-working Dependents Without Employer Coverage by Industry<sup>a/</sup>

Industry	<u>Workers and Dependents Without Employer Coverage</u>		<u>Workers Without Employer Coverage<sup>b/</sup></u>		<u>Non-Working Dependents of Workers Without Employer Coverage</u>	
	Number (millions)	Percent	Number (millions)	Percent	Number (millions)	Percent
Agriculture/Forestry/Fishing	3.6	7.3%	2.0	7.1%	1.6	7.7%
Mining	0.2	0.4	0.1	0.4	0.1	0.5
Construction	5.3	10.8	2.7	9.7	2.6	12.4
Durable Goods Manufacturing	3.3	6.7	1.6	5.5	1.7	8.2
Non-durable Goods Manufacturing	2.7	5.5	1.5	5.2	1.2	5.8
Transportation/Communications	2.5	5.1	1.3	4.6	1.2	5.8
Wholesale Trade	1.7	3.4	0.9	3.2	0.7	3.4
Retail Trade	10.1	20.5	6.6	22.9	3.6	17.2
Finance/Insurance/Real Estate	2.5	5.1	1.5	5.2	1.0	4.8
Business and Repair Services	4.0	8.1	2.4	8.3	1.6	7.7
Personal Services	3.2	6.5	2.0	7.2	1.2	5.8
Entertainment/Recreation	0.7	1.4	0.5	1.8	0.2	1.0
Professional Services	8.2	16.6	4.7	16.3	3.5	16.8
Public Administration	1.3	2.6	0.7	2.5	0.6	2.9
Total persons (millions)	49.3	100.0%	28.5	100.0%	20.8	100.0%

<sup>a/</sup> Dependents include spouses and dependent children.<sup>b/</sup> Includes all persons employed sometime during 1987 age 18 and older.

Source: Preliminary estimates from March 1988 Current Population Survey data. Subject to revision. July 1, 1989.

Table 27

## Percent of Firms Not Offering Coverage By Reasons and Firm Size

Reason for Not Offering Coverage <sup>a/</sup>	Total	1-9	10-24	25-99	100+ <sup>b/</sup>	Less than 100	Less than 500
Insufficient Profits	67%	68%	62%	54%	36%	67%	67%
Insurance Costs	62	61	70	41	68	62	62
Turnover	19	17	31	36	83	18	19
Group Coverage Not Available	16	17	3	22	0	16	16
Lack of Interest	13	13	6	5	0	13	13
Administrative Costs	9	10	2	0	51	9	9
State Minimums	1	1	0	0	0	1	1
Other	9	8	21	5	54	9	9

<sup>a/</sup> Responses sum to more than 100 percent because of multiple answers.

<sup>b/</sup> Because virtually all firms with more than 500 employees offer health insurance, this size group has been combined with 100-499.

Source: Lewin/ICF analysis of SBA, Office of Advocacy, Health Benefits Data Base, 1986.



factor for increased risk associated with the lack of experience rating for the individual group. In addition to higher costs, some small employers may not have access to insurance at all because of their size or industry.

**e. Extent of insurance among workers without employer coverage**

About three-quarters of all uninsured persons are either employed or are nonworking dependents of workers who could potentially become covered by an employer plan if more employers offered health insurance. Not all workers who do not receive coverage from their own employers lack health insurance, however. They may obtain coverage from their spouse's employer, purchase non-group coverage, or become covered under public programs such as Medicaid.

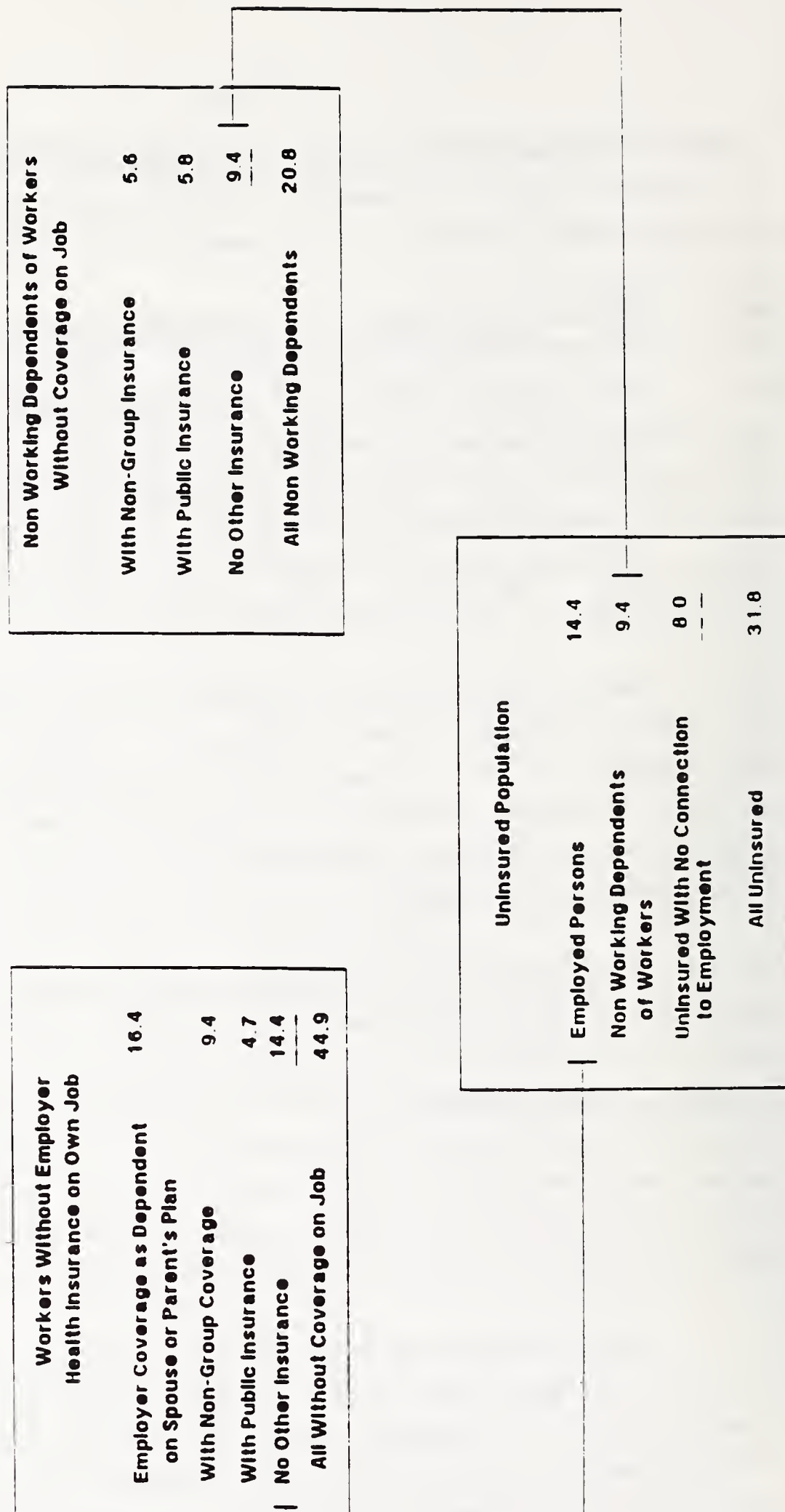
Among workers and their dependents who lack coverage on their own job, about 42 percent are insured (Figure 12). These include over two-thirds of the workers and over one-half of all nonworking dependents. About one-half of these individuals are covered by non-group policies; one-half by public programs. Dependents were slightly more likely to receive coverage from public programs than workers.

These data suggest two important points about the potential target efficiency of policies designed to expand employer health insurance coverage. First, if all employers were to provide health insurance coverage to all workers and their dependents, about 25 percent of the uninsured population (8 million) would continue to be uninsured. Second, many of those who would become covered by employer plans would be persons who are currently insured either in non-group plans or public plans. Thus, efforts to expand employer-based insurance would result in large shifts in sources of health insurance.

Although most of those who would become covered under an employer expansion are already covered under non-group and/or public health plans, an expansion of employer coverage is not necessarily inappropriate, however. Expanding employer coverage could result in substantial program savings to state and local governments as persons covered under public health plans shift

FIGURE 12

# **RELATIONSHIP BETWEEN WORKERS WITHOUT COVERAGE ON THEIR JOB AND THE UNINSURED POPULATION a/** (In millions)



to employer coverage.<sup>10</sup> In addition, the shift from non-group coverage to employer plan would reduce the number of underinsured persons and improve coverage, largely because employer plans tend to be more comprehensive than non-group plans. Further, employer contributions toward the premiums may permit individuals to shift spending to other uninsured but needed services, such as dental. Finally, some argue on equity grounds that all employers should bear comparable burdens for covering employees.

## 2. Employee Exclusion or Refusal to Accept Employer Coverage

Even where employers do offer health insurance coverage, many workers remain uncovered, either because they are excluded from coverage or they do not accept coverage. Both large and small employers exclude some workers from coverage. Approximately 68 percent of all employers exclude part-time workers. In addition, some plans use medical underwriting and exclude persons with existing medical conditions, such as diabetes and heart disease.

Approximately 13 percent of workers who are offered coverage do not accept it. This occurs for three major reasons: 1) the cost of the premium may be prohibitive; 2) they may already be covered by their spouse's plan; or 3) they do not perceive a need for health insurance and would rather have the income. It has been previously noted that about 16 million workers are covered by their spouse's coverage, but it is unknown what proportion were offered coverage on their own job.

In most employer health plans the employer pays a portion of the cost of insuring the worker while the employee pays the remaining portion of the premium. The SBA survey of employer health plans indicates that employers

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<sup>10</sup> Eligibility for Medicaid, Medicare, and other public programs does not terminate because an individual obtains coverage from another source. However, most public plans require that where private coverage is present, the private plan is primary payor for care while the public plan serves as secondary coverage.



paid about 86 percent of total plan premiums for workers with individual coverage (i.e., coverage for the worker only) and about 79 percent of total premiums for family coverage (i.e., coverage for the worker and dependents). However, the employer contribution requirement for employees varies across employers from as little as zero to as much as the full amount of the premium.

In nearly all employer plans, the employer pays at least some of the premium for employee health insurance. Of the 68.8 million workers who had employer coverage on their own job about 7 percent (4.8 million) indicated that the employee pays the full amount of the premium. About 40 percent of workers with coverage on their own job reported that the employer paid the full amount of the premium. For over one-half of all workers, however, the employer and the employee share in paying the cost of insurance (Table 28).

Employees of small firms are more likely to pay the full amount of the premium for employee coverage than are employees of larger firms. The percentage of workers who paid the full amount of the premium varied from a high of about 9.8 percent among workers in firms with 25 or fewer employees to a low of about 4 percent among workers in firms with 1,000 or more employees. Surprisingly, however, employees of small firms were more likely to have the entire premium paid by the employer than were larger firms. The employer paid the full amount of the premium for about 53 percent of all employees with coverage in firms where there were 25 or fewer employees. By comparison, among firms with 1,000 or more employees, only about 36 percent of workers were in plans where no employee contribution was required.

These differences in employer contribution practices reflect the diversity of small employers. Many small firms are composed of highly paid professionals such as physicians and attorneys who receive a generous package of employee benefits as compensation. However, many small firms, such as small retail trade or construction companies, employ lower skilled workers who receive few employee benefits.



Table 28

## Employer Premium Contribution for Workers with Coverage on Their Own Job

Number of Employees in Firm	All Workers With Coverage on Own Job (in millions)		Percentage of All Workers with Employer Coverage on Job	
			Employer Pays All Employer Pays Some	Employer Pays None
1-25	10.6	52.8%	37.4%	9.8%
25-99	9.1	42.5	51.6	5.9
100-499	11.7	38.3	56.8	4.9
500-999	4.5	37.9	57.1	5.0
1,000 or more	32.9	36.0	59.9	4.1
Average Weekly Earnings				
\$1-149	3.6	35.4	52.9	11.9
\$150-249	8.4	35.7	56.2	8.1
\$250-399	18.3	38.1	56.9	5.0
\$400-599	18.6	40.8	54.9	4.3
\$600-799	10.0	43.9	52.5	3.6
\$800 or more	9.4	44.2	50.9	4.9
All Workers	68.8	39.8%	53.2%	7.0%

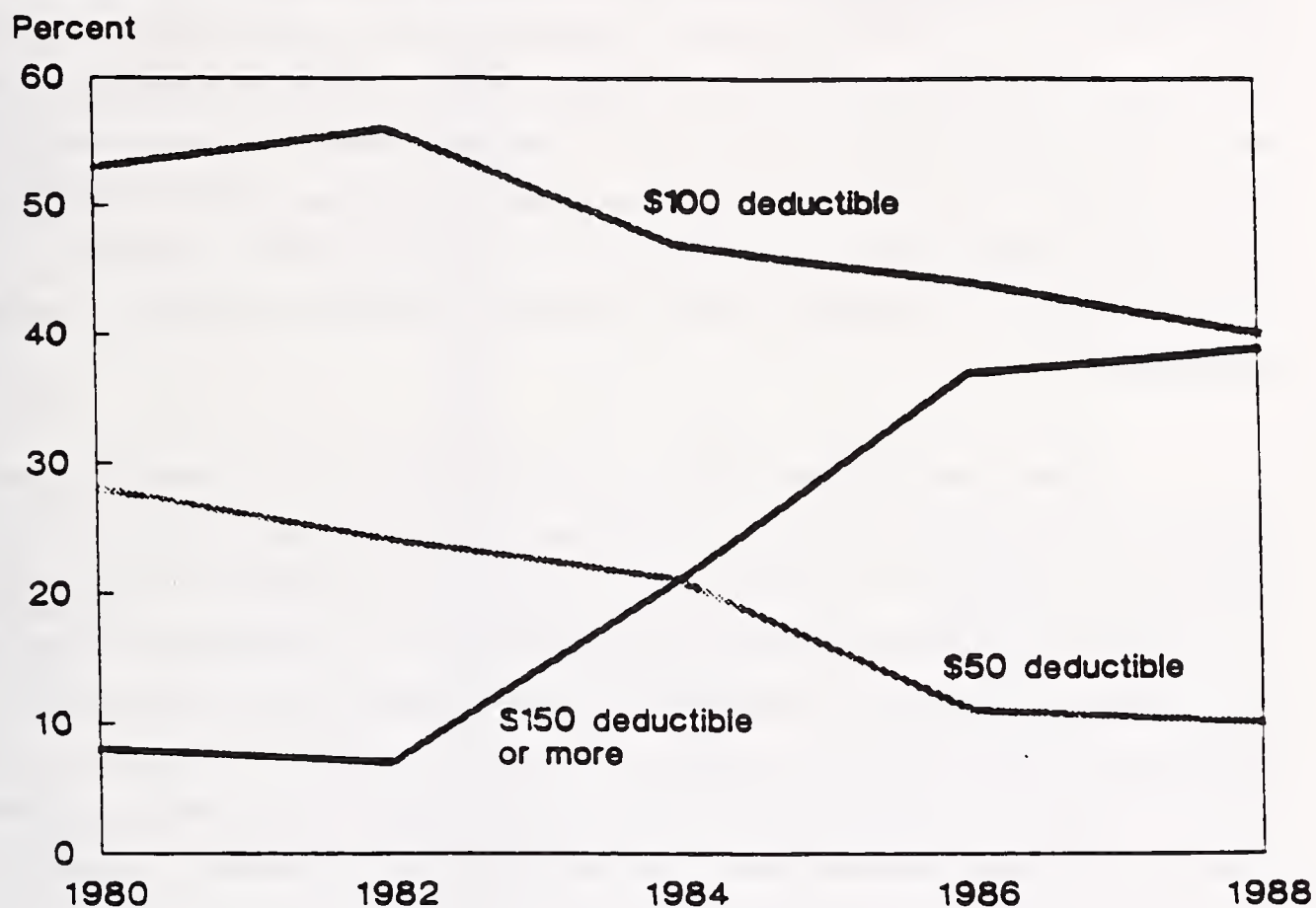
Source: Preliminary estimates from the March 1988 Current Population Survey data. Subject to revision.  
July 1, 1989.

The percentage of the cost of employer health insurance paid by the employer tends to increase with the income of the worker. The percentage of workers whose employers paid the full premium varied from a low of about 35 percent among those earning less than \$150 per week to a high of 44 percent among workers with weekly earnings of \$800. The percentage of workers paying the full amount of the premium was about 12 percent among those earning less than \$150 per week compared with about 5 percent among those with earnings of \$800 or more per week. Thus, lower income workers appear to confront higher out-of-pocket costs for employment-based insurance. Employers may contribute more toward the premium for higher income workers for two reasons. First, the market for these workers often requires a more comprehensive benefit package to recruit and retain workers. Second, workers may prefer this form of compensation, since the exemption from taxation of the value of the benefit has greater value as the income of the worker increases.

Recent evidence suggests that employers are requiring their employees to pay a larger share of the cost of insurance than in the past. In addition, while major medical protection is expanding, more restrictions are being placed on basic benefits and exclusions have been added for certain medical conditions. An examination of data from the Bureau of Labor Statistics survey of employee benefits in medium and large firms revealed that employees are paying more in terms of premium costs and deductibles. Fifty-four percent of workers had individual coverage completely financed by their employers in 1988, down from 72 percent in 1982. Thirty-two percent could also receive employer-paid coverage for their families, down from 51 percent in 1980 (BLS, 1989). Requiring workers to pay a higher share of the premium reduces the value of insurance and may encourage more low income or healthy employees to decline coverage. In addition, employee deductibles have increased since 1980 (Figure 13). Approximately 40 percent of employees have a deductible of more than \$150 compared to 8 percent in 1980.

FIGURE 13

**Trends in selected deductible amounts: Percent of full-time participants in medical plans with deductibles, medium and large firms, 1980-88**



Source: Bureau of Labor Statistics, Survey of Employee Benefits in Medium and Large Firms, 1988.

### 3. The Limits of Non-Group Insurance

For those not offered employer insurance and not eligible for Medicaid, non-group insurance can be an alternative source of coverage. As noted earlier, 18.3 million people identify this as their only source of coverage. Why don't more of the uninsured buy non-group insurance? For those with pre-existing medical conditions, such as diabetes, heart disease, asthma, and AIDS may be rejected as uninsurable when they apply for non-group policies. Where available, coverage may be prohibitively expensive. Indeed, even those without existing medical problems may find non-group coverage unaffordable.

Several mechanisms have been established to increase the availability of non-group insurance. Sixteen states operate or have enacted legislation to establish high-risk pools. These allow individuals who are otherwise uninsurable to purchase non-group coverage. Premiums for these policies are tied to a reference individual or small group policy. Losses are made up by assessments on health or life insurance carriers in the state, but most states (eight with operational plans) credit these assessments against the state's insurance premium tax. The premiums, while capped, are high and only two have put in place income-related subsidies to augment the risk-related subsidy provided by the pool product.

In 11 states without pools, Blue Cross plans serve as de facto risk pools by offering coverage to all on an ongoing or periodic basis. In some cases, these open enrollment periods are required by statute or regulation. The premiums the Blues charge for non-group coverage may also be held down by the insurance regulators, forcing the Blues to subsidize these plans from their other lines of business.

One state -- Rhode Island -- has an ongoing program that provides protection against catastrophic health expenses for all its citizens. Over 132 million people live in states with risk pools, Blues open enrollment, or a catastrophic program (Table 29). The remaining 22 states that have neither a high-risk pool, Blue Cross open enrollment policies, nor a catastrophic



Table 29

**States with Risk Pools, Blue Cross/Blue Shield  
Open Enrollment and Catastrophic Programs**

State	Population in 1986 (Thousands)	Risk Pools	BC/BS Open Enrollment	Catastrophic Programs
Alabama	4,052			
Alaska	534			
Arizona	3,319			
Arkansas	2,372			
California	26,981			
Colorado	3,267			
Connecticut	3,189	X		
Delaware	633			
D.C.	626		X	
Florida	11,675	X		
Georgia	6,104			
Hawaii	1,062			
Idaho	1,002			
Illinois	11,552	X		
Indiana	5,504	X		
Iowa	2,851	X		
Kansas	2,460			
Kentucky	3,729			
Louisiana	4,501			
Maine	1,173	X		
Maryland	4,463		X	
Massachusetts	5,832		X	
Michigan	9,145		X	
Minnesota	4,214	X		
Mississippi	2,625			
Missouri	5,066			
Montana	819	X		
Nebraska	1,598	X		
Nevada	963			
New Hampshire	1,027		X	
New Jersey	7,619		X	X
New Mexico	1,479	X		
New York	17,772		X	
North Carolina	6,333		X	
North Dakota	679	X		
Ohio	10,752			
Oklahoma	3,305			
Oregon	2,698	X		
Pennsylvania	11,888		X	
Rhode Island	975			X
South Carolina	3,377			
South Dakota	708			
Tennessee	4,803	X		
Texas	16,685	X		
Utah	1,665			
Vermont	541		X	
Virginia	5,787		X	
Washington	4,462	X		
West Virginia	1,918			
Wisconsin	4,785	X		
Wyoming	507			
Total Population (in thousands)	241,076	78,166	71,033	8,594

Source: Population data: U.S. Department on Commerce, Bureau of Census. State Population and Household Estimates with Age, Sex, and Components of Change, 1981-1987, Series P-25, No. 1024.

program may leave some high-risk individuals unable to obtain health insurance.

Some individuals can purchase insurance at group rates from their employer after they become unemployed through continuation coverage, but often the premiums are too high for most persons to afford. The continuation coverage provision in the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires employers to make their insurance plans available at group rates for up to three years for divorcees of employees and widows and dependents of former employees, and for up to 18 months for various classes of persons who lose coverage through loss of work.

Recent evidence suggests that few people opt for continuation coverage, largely because of its high cost. (In 1988, group premiums for private health insurance average about \$1,656 annually per eligible employee, or \$139 per month (DiCarlo, 1988).) An employer survey on the experience with continuation of coverage during 1988 found that of those eligible, only 10.6 percent elected to continue coverage. For those qualified for up to 18 months of benefits, the average length of coverage was almost 9 months, while those eligible for 36 months stayed with the COBRA benefits for an average of just over 14 months. Approximately 16 percent of the surveyed employers did not charge the full 102 percent of premium allowed by law for continuation of coverage, but instead subsidized an average 21 percent of the premium for their former employees (Spencer and Associates, 1989). Although few persons are taking advantage of this coverage, it has provided health insurance to 14,620 who may have been uninsured in the absence of the continuation of coverage provision.

#### 4. Limits of Medicaid Coverage

Although the Medicaid program was designed to provide access to medical care for certain groups of low income individuals, it does not cover all of the poverty population. Roughly 41 percent of persons with incomes below the poverty level were covered by Medicaid in 1986 (CRS, 1988). More-

over, Medicaid eligibility has not kept pace with the increasing number of people who are below poverty (Figure 14). As described above, whether persons are covered by Medicaid depends on whether they meet certain categorical requirements and income standards.

States have considerable flexibility in setting their Medicaid eligibility policies. Because of this, where people live makes a difference in whether they are eligible for Medicaid. Eligibility for Medicaid varies enormously by state (Table 30). The eligibility standard as a percent of poverty ranges from 14 percent in Alabama to 106 percent in California. A number of the options proposed to expand insurance coverage to the uninsured have focused on creating a national minimum income eligibility level for Medicaid.

In addition to income eligibility limitations, many people who meet the state income eligibility requirements for Medicaid do not meet the categorical requirements (e.g., single adults). Some have argued that the categorical requirements should be removed from Medicaid so that all poor persons can obtain coverage.

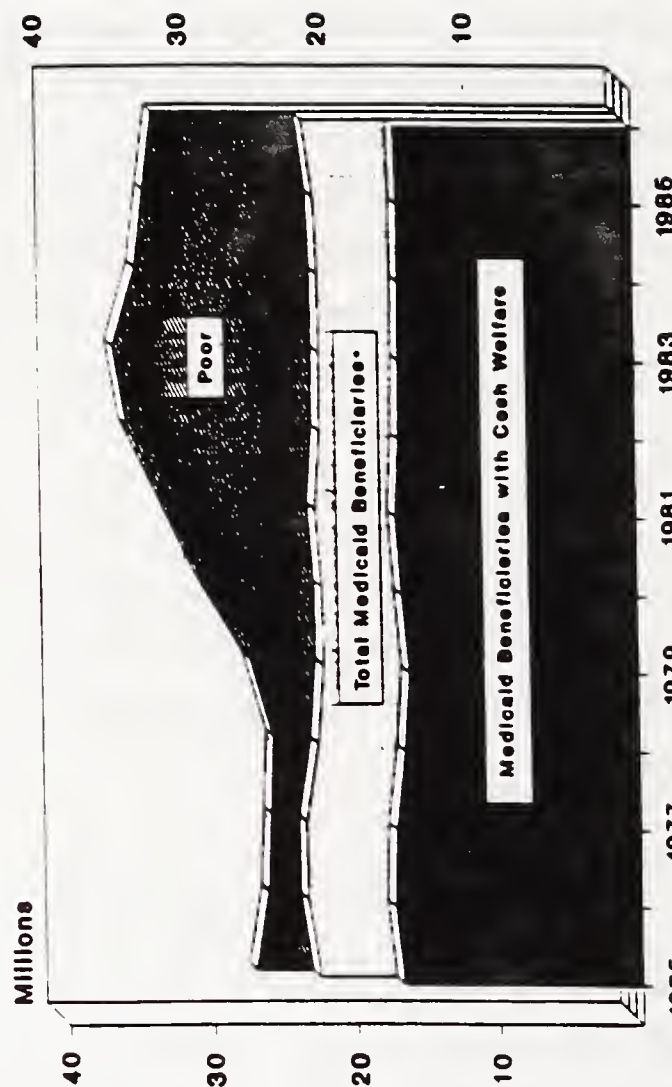
States have the option of establishing a medically needy program to cover persons who meet the categorical requirements of the Medicaid program, but whose income and resources are above the AFDC level, but below a medically needy standard. States have flexibility in setting the medically needy standard, but it cannot exceed 133-1/3 percent of the AFDC payment level. As of 1987, 36 states had medically needy programs. States may also limit eligibility to selected categorical groups. Two of the states with Medically Needy programs have excluded the disabled.

The medically needy program potentially extends the Medicaid program to persons of any income level who meet the categorical requirements provided that their medical expenses are large enough. This results because medically needy programs deduct medical expenses from a person's income to determine eligibility ("spenddown"). Thus, persons with health expenses sufficiently



FIGURE 14

# Trends in the Poverty Population and Medicaid Population, 1975-1986



• Total Medicaid beneficiary counts include some individuals with total cash income above the poverty line.

Source: Census Bureau and HCFA

From: Congressional Research Service, Medicaid Source Book: Background Data and Analysis, (Washington: U.S. Government Printing Office), 1988.



Table 3u  
Annualized Medicaid Eligibility Thresholds  
January 1989

<u>State</u>	<u>AFDC (Family of 3)</u>	<u>Percent of Poverty</u>	<u>Medically Needy (Family of 3)</u>	<u>Percent of Poverty</u>
Alabama	\$1,416	14.1%		
Alaska	9,708	77.2		
Arizona	3,516	35.0		
Arkansas	2,448	24.3	\$ 3,300	32.8%
California	7,956	79.1	10,704	106.4
Colorado	5,052	50.2		
Connecticut	6,408	63.7	8,520	84.7
Delaware	3,996	39.7		
D.C.	4,716	46.9	5,820	57.9
Florida	3,444	34.2	4,596	45.7
Georgia	4,512	44.9	4,404	43.8
Hawaii	6,684	57.8	6,684	57.8
Idaho	3,648	36.3		
Illinois	4,104	40.8	5,496	54.6
Indiana	3,456	34.4		
Iowa	4,728	47.0	6,300	62.6
Kansas	4,812	47.8	5,760	57.3
Kentucky	2,616	26.0	3,504	34.8
Louisiana	2,280	22.7	3,096	30.8
Maine	7,584	75.4	7,092	70.5
Maryland	4,524	45.0	5,304	52.7
Massachusetts	6,948	69.1	9,300	92.4
Michigan	6,864	68.2	6,588	65.5
Minnesota	6,384	63.5	8,508	84.6
Mississippi	4,416	43.9		
Missouri	3,420	34.0		
Montana	4,308	42.8	4,896	48.7
Nebraska	4,368	43.4	5,904	58.7
Nevada	3,960	39.4		
New Hampshire	5,952	59.2	6,852	68.1
New Jersey	5,088	50.6	6,792	67.5
New Mexico	3,168	31.5		
New York	6,468	64.3	8,508	84.6
North Carolina	3,192	31.7	4,296	42.7
North Dakota	4,632	46.0	5,220	51.9
Ohio	3,852	38.3		
Oklahoma	5,652	56.2	5,196	51.7
Oregon	4,944	49.1	6,708	66.7
Pennsylvania	4,608	45.8	5,400	53.7
Rhode Island	6,204	61.7	8,304	82.5
South Carolina	4,836	48.1		
South Dakota	4,392	43.7		
Tennessee	4,380	43.5	2,796	27.8
Texas	2,208	21.9	3,204	31.8
Utah	6,024	59.9	6,012	59.8
Vermont	7,548	75.0	10,092	100.3
Virginia	3,492	34.7	4,296	42.7
Washington	5,904	58.7	7,188	71.5
West Virginia	2,988	29.7	3,480	34.6
Wisconsin	6,204	61.7	8,268	82.2
Wyoming	4,320	42.9		
Average State	\$4,791	47.1%	\$ 6,066	60.1%

Source: National Governors' Association, January 1989.

large that their income less health expenses falls below the medically needy income limit would be eligible for Medicaid.

In states without medically needy programs, persons who are categorically eligible for Medicaid, but whose incomes are above the Medicaid eligibility level cannot obtain coverage. This is known as the "Medicaid notch problem," whereby one additional dollar of income can mean the complete loss of Medicaid coverage. This is a particular problem for the disabled who are most likely to incur large medical expenses and could benefit from the medically needy spend down provision (Rymer, 1989).

The period over which income is counted in determining eligibility and the period of recertification for eligibility are key factors in determining the number of people eligible for Medicaid. Eligibility for AFDC, SSI, and Medicaid is currently based on a monthly accounting period, whereby a person's income in a given month is used to determine eligibility. The period of recertification varies under these programs with eligibility for AFDC recertified monthly. While some states certify eligibility monthly for all Medicaid enrollees, some states recertify eligibility for SSI every three months and those with Medicaid without cash assistance every six months. In designing Medicaid expansion options, the period over which income is counted and the period of recertification are important policy considerations. For example, changes in the accounting period would result in differences in the number of people affected by an option. A shorter accounting period is likely to qualify more people with fluctuating incomes or those spending down to medically needy with small, recurring expenses.

Medicaid eligibility is complex and this complexity creates unanticipated gaps in the programs reach. For example, the provisions in the Medicare Catastrophic Act requiring Medicaid coverage be extended to pregnant women, infants, the elderly and disabled persons below poverty have not been integrated with medically needy spenddown provisions. The medically needy standard is linked with the AFDC payment standard. Thus, while the income standard for Medicaid has been increased for these population groups to the

poverty level, the medically needy standard remained the same. Therefore, a pregnant women with income just below the poverty level is eligible for Medicaid coverage, while a pregnant women just above the poverty level would need to spend down below the poverty level to the medically needy level.

A recent longitudinal study of Medicaid enrollees found that Medicaid operates as a long-term program of health care for two-thirds of its enrollees, but as a short-term, stop-gap program for the other one-third. The study examined the prior and subsequent insurance status of persons moving on and off Medicaid. Of these moving on Medicaid, 41 percent were privately insured and 57 percent were previously insured. The remainder had other public or private insurance. Of those moving off Medicaid, the majority (55 percent) were subsequently uninsured (Short, Cantor, Monheit, 1988).

Some of those who are uninsured are eligible for Medicaid but do not enroll in the program. A Lewin/ICF analysis of Medicaid enrollment found that 72.5 percent of those eligible for Medicaid actually enroll (Table 31). This finding is similar to household surveys in Colorado and Florida that found only about three-fourths of those who meet AFDC or SSI income and asset requirements for Medicaid actually enrolling in the program. However, enrollment rates vary by age, health status, income, and region.

Medicaid enrollment is higher among younger children. About 83 percent of those eligible under age 6 enrolled compared to 70 percent of those between ages 6 and 14. Among adults enrollment decreases with age to age 65 and then increases. In addition, about 82 percent of eligible pregnant women enroll.

As expected, enrollment varies by self-reported health status. About 80 percent of persons who report to be in fair or poor health enroll compared to about 70 percent for persons in excellent or good health. Enrollment rates do not vary much by sex, largely because children are included in these data.

Table 31

Estimated Number of Noninstitutionalized Persons  
Eligible for and Enrolled in Medicaid in 1989<sup>a/</sup>

	Persons Eligible for Medicaid Some Time in Year		
	<u>Eligible</u>	<u>Enrolled</u>	<u>Percent Enrolled</u>
Children			
<6	5,858	4,881	83.3
6-14	6,054	4,226	69.8
15-18	2,432	1,782	73.3
Adults			
<24	3,234	2,624	80.1
25-34	4,075	2,705	66.4
34-64	5,902	3,816	64.7
65+	4,626	3,291	71.1
Self-reported Health Status			
Poor/Fair	7,843	6,205	79.1
Good/Excellent	24,340	17,119	70.3
Sex			
Male	13,135	9,395	71.5
Female	19,047	13,930	73.1
Annual Family Income as a Percentage of the Poverty Line			
<75%	15,003	12,310	82.0
75-99%	4,790	3,637	75.9
100-125%	2,731	1,875	68.7
125-150%	2,267	1,460	64.4
150%+	7,391	4,042	54.7
Pregnant Women	1,589	1,302	81.9
Region			
Northeast	6,782	5,000	73.7
Midwest	7,258	5,210	71.8
South	8,165	6,192	75.8
West	<u>9,978</u>	<u>6,923</u>	<u>69.4</u>
Total	32,183	23,325	72.5

<sup>a/</sup> Excludes persons in institutions.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

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Medicaid enrollment declines as family income increases ranging from 82 percent for families with incomes below 75 percent of poverty to 55 percent among families with incomes greater than 150 percent of poverty. At higher income levels these families may be unaware of Medicaid eligibility because they are not eligible for cash assistance. They may also have more choices for health insurance than lower income families.

Further, Medicaid enrollment varies by region with enrollment being highest in the South (76 percent) and lowest in the West (69 percent). Enrollment in the Northeast and Midwest is about 74 percent and 72 percent, respectively.

The reasons for enrollment shortfalls are varied, but they often relate to misunderstandings about the program and the application process and a lack of awareness on the part of these populations, and the providers that serve them, that Medicaid can be available without cash assistance. Some eligible persons choose not to enroll in Medicaid because they view it as a stigma to be on a public program. In addition, the complexity of the documentation and application process may discourage enrollment in some states.

##### 5. The Personal Choice to Remain Uninsured

Some of the uninsured choose not to obtain health insurance either by not enrolling in Medicaid or by not accepting employer-based coverage. Approximately 28 percent of those who are eligible for Medicaid do not enroll (Lewin/ICF, 1989). About 13 percent of persons offered employer-based coverage do not accept it. However, not all of these are uninsured. Some do not accept employer-based coverage because they are insured by a spouse or as a dependent on a parent's plan. Reasons for not enrolling in Medicaid or accepting employer-based coverage were noted above.

## G. PUBLIC AND PRIVATE EFFORTS TO EXPAND INSURANCE

In recent years a number of initiatives have been undertaken to expand access to insurance. At the federal level, these have focused on Medicaid expansion, and assuring access to Medicare Part B for the poor, elderly, and disabled. State and local level programs have focused on Medicaid, employer-based insurance, and expanding non-group insurance. This section describes the major initiatives being undertaken and discusses the impact these programs have had or are likely to have on the number of uninsured. The initiatives discussed include: 1) Medicaid expansion; 2) requirements for employer-based insurance; 3) efforts to increase employer access to insurance; and 4) assisting individuals in obtaining coverage.

### 1. Medicaid Expansion

In the past few years, Congress has passed a number of expansions to the Medicaid program. These have focused on expanding eligibility for pregnant women and children, and expanding Medicaid buy-in to Medicare for the SSI population. Many of these are optional for the states; a number are mandatory. We review the recent Medicaid expansions by the population they are intended to reach and present current data on the number of states taking advantage of the optional provisions.

- Elderly and disabled with incomes up to the poverty level. The 1986 Omnibus Budget Reconciliation Act (OBRA86) gave states the option of providing Medicaid coverage to the elderly and disabled with incomes up to a state-established level not exceeding 100 percent of poverty. States choosing this option are also required to cover some newly eligible pregnant women and infants. To date, four states have taken advantage of this option. OBRA 1986 also introduced an option for states (through Medicaid) to pay Medicare premiums, copayments, and deductibles for the elderly and disabled with incomes up to the poverty level.<sup>11</sup> However, the passage of the Medicare Catastrophic Coverage Act of 1988 mandates the phase-

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<sup>11</sup> Note that all elderly and totally disabled persons are eligible for Medicare, regardless of income. That program does not, however, cover a number of services reimbursable by Medicaid -- most notably, prescription drugs and long-term care.

in of Medicaid coverage or Medicare Part B payments for the elderly and disabled up to the poverty level of four years between now and 1992.

- **Children under age 8 below poverty.**<sup>12</sup> OBRA86 created a new optional categorically needy group of pregnant women, infants up to age 1, and children up to age 5 in families with income below a state-established level between the AFDC level and 100 percent of the federal poverty line. OBRA87 then gave states the option of extending Medicaid coverage to children under 8 years of age in families with incomes below the poverty level. NGA data shows that 32 states have elected this option. Nine states have accelerated coverage of children up to age 6, while 23 other states continue to phase in coverage of children between 2 and 8 one year at a time. OBRA87 also required states to extend coverage to all children under age 7 in families with incomes below the AFDC payment standard ("Ribicoff children"). States have the option of extending this coverage to all older children under age 21 (or under 20, 19, or 18) or reasonable categories of these children (e.g., children in two-parent families) who meet AFDC income and resource requirements, but not categorical requirements. Most recently OBRA89 mandated coverage for children under age 6 in families with incomes below 133 percent of the poverty level (\$16,093 for a family of four).
- **Pregnant women and infants up to 185 percent of poverty.** OBRA87 gave states the option of extending eligibility for Medicaid to pregnant women and infants up to 185 percent of poverty or about \$21,450 for a family of four. The Medicare Catastrophic Act of 1988 then mandated coverage of pregnant women below the poverty level by 1990. OBRA89 recently mandated coverage of pregnant women and infants with incomes below 133 percent of poverty by April 1, 1990. As of May 1989, 45 states have expanded their Medicaid programs by creating special income limits for pregnant women and infants. Thirteen states raised the income thresholds for Medicaid to 185 percent of poverty; 29 states have established limits at 100 percent of poverty; and 3 states maintain levels above AFDC limits but below 100 percent of poverty (NGA 1989).
- **Continuous coverage of pregnant women.** States have the option of providing continuous eligibility to pregnant women from the time they qualify for Medicaid through 60 days after the birth of the child. The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) introduced this provision which assures that breaks in pregnancy-related care do not occur, even for women who do not continuously meet Medicaid eligibility criteria. Thirty-eight states have guaranteed pregnant women continuous eligibility throughout their pregnancy.



- Presumptive eligibility for pregnant women. OBRA86 allowed states to provide presumptive eligibility for pregnant women so that they can receive prenatal care while they are waiting to obtain enrollment in Medicaid. Twenty states have adopted the presumptive eligibility option.
- Severely disabled children living at home. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) allowed states to extend Medicaid coverage to severely disabled children, regardless of their family's income or resources, who would receive Medicaid coverage if they were living in an institution, but who are living at home with less expensive services. This option has been implemented in 19 states.
- Families who lose their AFDC because of increased earnings will become eligible for a Medicaid extension of 12 months rather than the current 4 months, beginning in April 1990. The Family Support Act (Welfare Reform) of 1988 includes this requirement as part of a broader effort to encourage self-sufficiency, and gives states the option of charging a premium for the latter 6 of the 12 months.
- Unemployed parent coverage is mandatory in states by 1990 as required by the Family Support Act.

## 2. Requirements for Employer-based Insurance

Two states have requirements for employers to provide insurance to their employees. Hawaii mandates employer coverage and Massachusetts will levy a tax penalty on employers who do not provide insurance:

- Hawaii Prepaid Health Care Act of 1974. The state of Hawaii was the first state to require all employers to provide health insurance for eligible employees. Defined under the Prepaid Health Care Act of 1974, this law requires both employers and employees to contribute to health insurance premiums, with the employer paying at least half, and the employees limited to paying 1.5 percent of their monthly gross earnings. The requirement applies to employees working more than 20 hours per week. Dependent coverage is optional.

The potential for other states to enact similar legislation is unclear in light of the passage of ERISA also in 1974. In 1980, Hawaii's act was challenged in light of ERISA provisions. The U.S. Supreme Court ruled against Hawaii, sustaining a lower court ruling that found that Congress intended broad preemption of state regulation and did not provide an exemption of employer-mandated state laws (Lewin & Associates, 1983). Hawaii's recourse was to



seek a change in federal legislation. Congress granted Hawaii an exemption from ERISA as it related to the Prepaid Health Care Act. The exemption is limited to the Hawaii program and only as it existed on September 2, 1974 (except for changes in administration), and further states that the amendment shall not be considered a precedent with respect to extending such an amendment to any other state law (Lewin & Associates, 1983).

Prior to the enactment of the Prepaid Health Care Act 5 percent of Hawaii's population was estimated to be uninsured. This rate dropped to under 2 percent in the years following the enactment, but rose again recently. Despite this mandate, an estimated 5-9 percent of the population still lacks health insurance. These are individuals unassociated with the work force or excluded from coverage because they are part-time or seasonal employees, or dependents of workers. To extend coverage to this population, the state has just passed a new State Health Insurance Program designed to fill the gap between Medicaid and private insurance. The program places an emphasis on preventive and primary care, and makes the insurance premium available on a sliding scale.

- Massachusetts Health Security Act was passed last year to assure universal insurance coverage for all Massachusetts residents. The Act created two programs. The first program entitled "Common-Health" consists of several state-sponsored health insurance programs designed to provide health insurance to all persons who cannot obtain health insurance from their employer or are ineligible for Medicaid.

The second major component of the Act consists of tax incentives for employers to provide private health insurance. As of January 1, 1992, employers of six or more employees must provide health insurance to their employees working more than 30 hours per week or 520 hours in a 26-week period and their dependents. Tax credits are provided for small employers, new firms, and those who can prove that providing coverage is a financial hardship. A tax is levied against all employers who do not offer coverage.

The state is currently engaged in collecting the data necessary for designing the state-sponsored programs scheduled for implementation in 1992. The studies are designed to gather information on the characteristics of the uninsured, including an assessment of health and employment status. The state has also requested proposals for the development of insurance products for small businesses.

- New York "UNY\*Care" Proposal. A recent proposal from New York's health commissioner would have the state require that all employers provide a yet undetermined level of health insurance to their employees. While the state legislature has been presented several financing/structural options to consider, the foundation of any program would be the health care card issued to each state

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resident. Providers would use the card to bill eligible health care costs to a central system that would then disburse the costs to either the person's private insurer or, if the cardholder has no other insurance, to a state-run program.

### 3. Efforts to Increase Employer Access to Insurance

A number of efforts are being aimed at reducing the cost of insurance to small employers:

- **Multiple Employer Trusts.** In an effort to provide health insurance to employees, small employers may group together to form a Multiple Employer Trust (MET). The MET is intended to enable its participants to make health coverage available to their employees by reducing the administrative costs of providing insurance and spreading risk over a broad pool, thus improving the stability of the group. METs may seek coverage from an insurance company or the group may self-insure. The impetus to form a MET may come from small employers within a single industry or community, or a third party administrator specializing in MET administration may promote the creation of an employer trust to a group of employers.

The experience of METs has been mixed. METs became popular in the 1970s, in part as a result of rising health insurance costs and the enactment of the federal Employee Retirement Income Security Act (ERISA) (Bovbjerg, 1986). ERISA appeared to exempt METs from state regulation through its preemption of state regulation of employee benefit plans, but failed to be explicit in the nature of the regulations -- federal or state -- to which METs would be subject. The regulatory status of METs was particularly unclear for those METs not run by employers or unions and at least partially self-insured (Bovbjerg, 1986).

This ambiguous legislation encouraged the proliferation of administrative agents which marketed the MET concept to small employers and then developed METs. Often these were self-insured with limited reserves, and the potential for administrative mismanagement was particularly high. The lack of specific regulations made it possible for METs to avoid the reserve restrictions and monitoring of state insurance departments, despite regular outcries from the states over the apparent federal preemption of their ability to regulate METs within their borders. The result was a succession of MET failures as administrative expenses grew due to high marketing costs, and as benefits' claims outpaced premium revenues due to unsound premium/benefit structures and depleted reserves (Donohue, 1982; Scallet, 1983).



In an attempt to clarify the regulations and protect employer groups from ill-qualified MET administrative agents, Congress passed the 1983 Erlenborn-Burton Act. This act amended ERISA to provide that a MET that is insured fully or is self-insured must abide by state insurance laws.

The implications of this legislation for the future of METs is not clear. The MET concept has been tarnished by the gross mismanagement of administrative agents in the past. Furthermore, the long-term stability of METs and MET administrators has been, and continues to be, questioned. The problems that can discourage insurance coverage by small firms -- high turnover rates of employees, the need for high rates of participation within the group to insure a broad spread of risk and avoid adverse selection -- remain even where MET administration has been sound.

Notwithstanding the problems that have been encountered by METs, some analysts remain optimistic about the future of METs (Washburn, 1987; Kerr, 1989). These analysts cite the potential for METs to enable small employers to keep pace with benefit plans offered by larger firms. They argue that if a MET is selected carefully, considering its stability, its contribution/benefit structure, and the history of its administration, it may offer small employers an opportunity to provide health insurance to employees at reasonable cost.

- **Oregon tax credit.** Oregon passed legislation providing a tax credit to employers with 25 or fewer employees who do not offer health insurance. The first policies under this tax credit were issued in May of this year. Eligible firms are those where the employer either did not offer insurance or did not contribute to the premium in the past two years. Eligible employees are those who work more than 17.5 hours per week. If the employer takes advantage of the tax credit, all employees must enroll in the plan. Employers must contribute at least 75 percent of the required minimum benefits package. They then receive a tax credit of 50 percent of the total amount paid by the employer during the year or \$25 per month per eligible employee, whichever is less. As of November 1989, 10 firms had enrolled for the tax credit.
- **Massachusetts tax credit.** Part incentive, part subsidy, the state of Massachusetts is offering firms with less than 50 employees tax credits for the two years prior to 1992 if they will begin providing health care coverage now. To be eligible, a firm must not have offered insurance since 1985. Each small business newly offering health care coverage will be permitted a 20 percent tax credit in 1990, and a 10 percent credit in 1991. Beginning in 1992, the state will levy a tax of up to 12 percent of the first \$14,000 in wages for each employee (in a firm of six or more person) not covered by a private, employer-sponsored health insurance program that costs an average of \$1,680 per year per employee.

- California "Small Employer Health Coverage Incentive Act." A program that has not yet been implemented, this initiative will offer tax credits to employers with fewer than 25 workers who have not provided a health plan in the two years prior to state program implementation. The tax credit will consist of \$25 per month per covered individual, or 25 percent per month of the insurance costs, whichever is greater. Benefits must include both inpatient and outpatient hospital and physician services, and diagnostic tests. Should the employer select coverage that includes either prenatal/well-baby care, and/or mental health benefits that cover some hospitalization and outpatient visits, they are eligible for an additional tax credit of \$5 per month. Employers will not be offered this incentive until the state of California foresees a real growth rate in personal income of at least 4 percent, with the first possible year of implementation being 1990.
  
- RWJ Insurance Demonstrations. The Robert Wood Johnson Foundation has been active since 1986 in sponsoring private initiatives at the state and local level to improve access to health care for persons who lack insurance. Though RWJ did not initially intend to have the insurance demonstration projects specifically geared toward the small employer, the result to date has been an almost exclusive emphasis on expanding insurance possibilities for the small business with less than 25 employees. The general goal has been to lower the costs of insurance by pooling or subsidizing administrative costs, tailoring benefits, and obtaining deep discounts from providers. A total of 15 grants were awarded in two rounds. Fourteen of the projects are seeking to develop new health insurance mechanisms for small businesses, and one project is offering a health insurance brokering and information service. Some of the strategies include limiting plan benefits; encouraging greater employer cost-sharing; subsidizing the plan premium; and reducing the cost of services through either managed care or provider discounts. Of the 14 seeking to develop an indemnity or managed care product for small business, 9 are now in the enrollment phase and 3 have completed their projects. A brief description of each of the projects follows:
  - Central Alabama Coalition for the Medically Insured - administered through the University of Alabama at Birmingham Hospital, this project seeks to reduce the cost of insurance by limiting benefits and negotiating discounts from both public and private providers. The coalition has negotiated final contracts with providers, but has not begun enrollment.
  
  - Health Care Group of Arizona - the first of the projects to begin enrollment was created by the Arizona Health Care Cost Containment Commission to provide medical coverage to uninsured small businesses with 25 or fewer employees. The program makes insurance affordable to workers by using existing managed care health plans developed for the state Medicaid program.

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Enrollment began in January 1988 and now totals over 844 employees and their dependents.

- **Denver Department of Health and Hospitals** - with the goal of creating a low-cost comprehensive indemnity insurance plan for small businesses. High deductibles and copayments are likely to make premiums affordable, but for low income enrollees, the state's Medical Indigency Fund may subsidize all or part of the inpatient deductibles and copayments. The project has just begun enrollment.
- **Florida Small Business Health Access Corporation** - this project's aim is to offer an affordable comprehensive health package through an HMO (managed care) delivery system. The project is designed to show how state funds can be used to minimize risk and enhance affordability through innovative reinsurance mechanisms and premium subsidies for family coverage. The project has enrolled over 160 small businesses insuring 802 employees and dependents.
- **Maine Managed Care Insurance Demonstration** - this project aims to test a subsidized health insurance and managed care program for small business groups, the self-employed, and AFDC recipients at two sites. At one site in Brunswick the program has enrolled over 540 members from 158 businesses, many of them self-employed individuals. State subsidies are available for persons under 200 percent of poverty. To minimize medical underwriting, the project has a formal linkage with the state high-risk pool.
- **Michigan Health Care Access Project** - the Michigan League for Human Services, together with the Michigan Department of Social Services, initiated the Health Care Access Project with the primary goal of increasing the number of insured individuals by subsidizing employers' and employees' cost of health insurance. The program also decreases dependency on welfare by providing transition health insurance to former AFDC and general assistance recipients entering the workforce. The project pays two-thirds of the actual cost of a traditional policy premium for employees whose family income is below 100 percent of poverty and pays one-third for those with wages below 200 percent of poverty. About 750 employees and dependents had joined the plan by September 1989.
- **New Jersey Health Care for the Uninsured Project** - this project entails two separate Department of Health initiatives aimed at increasing insurance coverage, the Reinsurance Program and the Dependent Coverage Program. These programs are still being developed and enrollment is not expected to begin for either plan until 1990. The Reinsurance Program is targeted to small businesses and is designed to test the feasibility of using the state uncompensated care payment system as a reinsurance

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mechanism for participating insurance companies. The Dependent Coverage Program will use a direct premium subsidy for an insured individual's purchase of coverage for uninsured family members.

- San Diego Council of Community Clinics - this project is designed to provide affordable insurance to low-income and minority workers through the use of a network of community health centers. Substantial inpatient and referral discounts and traditional inpatient utilization review will help lower costs and keep the premiums down. Enrollment is scheduled to begin January 1990.
- South Cove Community Health Center - this project consisted of a feasibility study that has now been completed. Its main focus was the formation of a risk pool of small employers in Boston's Chinatown with outpatient care to be managed and delivered by a local health center. While the RWJ grant has terminated, the project continues to pursue this goal and has requested support from the state of Massachusetts for the demonstration phase.
- Tennessee Primary Care Association (MEDTRUST) - located in Memphis, this project is offering a comprehensive benefit plan with a substantial hospital discount provided by a major medical center. As of March 1989, a total of 388 persons were covered.
- United Way of the Bay Area - located in the San Francisco-Oakland region of California, this project will collect and provide health benefit information to small businesses in the area. The project seeks to educate uninsured employers about the importance of health insurance. It will not only act as a referral service on health plans available to small firms, but also help them develop the skills necessary to select effective plans.
- Utah Community Health Plan - Intermountain Health Care Foundation uses a network of community health centers and substantial discounts (up to 35 percent) from hospitals and specialist physicians to provide affordable coverage for small business employees and their dependents.
- HealthSystem Resources of Seattle - RWJ provided a planning grant for this project to create a primary care network that would affiliate with hospitals to form managed care systems. Now a state-run plan called the Washington Basic Health Plan, traditional providers of uncompensated care will bid for the right to deliver care to subscribers.
- West Virginia Indigent Health Care Services Project - based on previous experiences provided through the West Virginia Public



Employees Insurance Agency (PEIA), a state-wide multiple employer trust (MET) that provides health insurance to state and local government employees, this project is exploring the feasibility of extending coverage to small businesses within the state. Originally supported by a RWJ planning grant, this project is currently waiting for the state legislature to provide funding for implementation.

- Wisconsin Small Employer Health Insurance Maximization Project - this project will provide state insurance premium subsidies directly to low income uninsured workers. The objective is to encourage existing insurance companies to develop and aggressively market comprehensive benefit packages to employers with 19 or fewer employees and to motivate these employers to offer insurance to their workers.

Though only 9 of the 13 projects that are operational have just started enrolling beneficiaries as of October 1989, some early experiences provide lessons worth noting. Observations include:

- Price is the chief consideration of both the employer and employee when choosing an insurance plan;
  - The smallest employers have shown the most interest in the demonstration projects; the average size of participating firms ranges from 2 to 5 employees;
  - Insurers who market to firms with 10 or fewer employees tend to have strict medical underwriting;
  - METs are effective in helping develop insurance products for small businesses, but still have difficulties keeping premiums affordable;
  - An insurance plan that offers only basic benefits is not easily sold to either small employers or their employees; both groups favor plans that offer protection from major physician and hospital expenses;
  - An aggressive marketing effort must be generated that both creates an awareness of the need for coverage and advertises a specific product;
  - An effective partnership between the public sector, with its initiative and concern for the low income uninsured, and the private sector, with its servicing and marketing experience, may be necessary to ensure the success of a program.
- New York Employer Incentive Subsidy Program. The New York Employer Incentive Program, together with the Individual Subsidy Program, constitute New York's Regional Pilot Program for the Uninsured. This program is directed to small employers of 20 or

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fewer employees who have not provided group health coverage to any of their employees since January 1, 1988. The state will contribute to an "approved organization or carrier" to reduce premium costs by 50 percent for employees and/or their dependents. Employees may not be required to contribute to their premium costs, but they would be responsible for any deductibles or copayments related to coverage services. Employers must contribute to at least 50 percent of the premium costs. In the event of oversubscription to the program, employers with the lowest average salaries of employees will be selected first. This insurance is subsidized for 18 months.

#### 4. Assisting Individuals in Obtaining Coverage

A number of strategies are available to assist individuals in obtaining coverage. These are the availability of high-risk pools, catastrophic programs, state requirements for Blue Cross/Blue Shield plans, and state subsidized non-group insurance. These are described further below.

##### a. High-risk pools

Sixteen states have established risk pools for the medically uninsurable or enacted legislation to establish a pool. These risk pools offer health insurance to people who are otherwise unable to purchase it. Risk pools spread the financial risk of covering otherwise uninsurable individuals among all health insurance plans (excluding self-insured employers) in the state. Risk pools are typically independent entities governed by a board and administered by an insurance carrier which is selected by the board.

The risk pools vary from state to state, but they generally require that all life and health insurers doing business in the state join the association, and offer individual, comprehensive health insurance to people considered to be otherwise uninsurable. Thus far, these pools offer a typical indemnity benefit package. Participation is generally limited to persons who have been rejected for coverage by at least one insurance company, or who suffer from serious health conditions.



Enrollment in risk pools has been low (Table 32). In all states, enrollment is less than 3 percent of the uninsured in the state. It has been estimated that one percent of the under-65 population is uninsurable. Applying this percentage to the uninsured in each state, Griss estimated that the Minnesota pool was reaching one-third of the target population and the North Dakota pool one-quarter, but that other pools for which data were available were reaching less than 10 percent of the target groups, some much less (Griss, 1989). Low enrollment is largely related to high premiums and lack of aggressive marketing efforts (Bovbjerg and Koller, 1986; Burda, 1989). Marketing may have been a low priority for risk pools because reaching and enrolling more uninsureds is not in the "best fiscal interest of most pools' constituent insurers or their agents" since the cost of claims has tended to exceed premium contribution (Bovbjerg and Koller, 1986). Expenses in excess of premium income are distributed among the life and health companies as assessments in proportion to their volume of business in the state. In most states, however, these assessments may be used as credits against premium taxes, thus defacto making the funding of the subsidy a general revenue tax expenditure. Thus, outreach may not always be in the states interest either, since most plan losses are financed directly from state general revenues.

Premium rates for pool coverage are capped by the state and range from 125 percent to 400 percent of the average premium rate for non-group coverage. In Maine, for example, the premium ranges from \$57 per month for children under 17 years of age to \$213 per month for men over 64 years of age.

The Maine and Wisconsin risk pools include a provision to subsidize the premium for low income enrollees. Maine subsidizes low-income enrollees up to a maximum of one-third the cost of the premium. Eligibility for the subsidy is individually determined based on family size and income. To date 15 out of 100 enrollees are receiving subsidies, with the average subsidy being 26 percent of the premium.

Wisconsin subsidizes 33 percent of the premium cost for those individuals with incomes under \$6,000. Approximately 21 percent of the risk pool

Table 32  
Number of People Enrolled in Risk Pools

States	Risk Pool Enrollees (1/1/88)
Connecticut	2,209
Florida	1,562
Illinois	N/A
Indiana	2,610
Iowa	276
Maine	100 <sup>a/</sup>
Minnesota	12,393
Montana	31
Nebraska	545
New Mexico	N/A
North Dakota	1,463
Oregon	790
Tennessee	N/A
Washington	N/A
Wisconsin	2,476

<sup>a/</sup> Currently enrolled as of May 1989 (program implemented in September 1988).

Source: Friedman, E. "Are Risk Pools Being Oversold as a Solution?" Hospitals, November 1988, p. 100-104.

enrollees in Wisconsin are currently subsidized. In fiscal year 1987-88, the risk pool suffered a shortfall of approximately \$1.2 million.

Studies of pool participants have shown that enrollees tend to be women over 40 years of age. Only a small number of pool enrollees are employed, largely because they are disabled. A survey of pool enrollees in Wisconsin (where less than 1 percent of the uninsured are enrolled in the pool) found that 40 percent of participants had incomes less than \$12,000; 42 percent had incomes between \$12,000 and \$25,000; and 18 percent had incomes greater than \$25,000. The Wisconsin survey also found that enrollees were likely to be married and suffering from heart conditions, hypertension, and/or cancer.

#### b. Catastrophic programs

During the 1970s, four states (Alaska, Maine, Minnesota, and Rhode Island) created catastrophic programs to protect individuals and their families from being financially devastated by large medical expenses. Only the Rhode Island program is still operational. Recently two other states (New Jersey and New York) have established catastrophic programs. This section describes the experience with catastrophic programs, why they were discontinued, and describes the Rhode Island, New Jersey, and New York programs.

State financed catastrophic programs are structured similarly. Each program reimburses eligible individuals or families who have incurred large medical bills. They are the payers of last resort, and are intended to be secondary to all other public and private insurance programs. These programs are targeted to a small group of people.

The programs were discontinued largely because they served few people and monies were targeted to other programs. For example, the Maine Catastrophic Illness Program reported a decrease in eligibles of 66.8 percent between January 1982 and January 1983, from 280 eligibles down to 93. This followed an 87.7 percent drop in eligibles between July 1981 and May 1982,



largely a result of the implementation of a \$7,000 deductible and more restrictive eligibility criteria (Maine Department of Human Service, January 26, 1983). The Maine catastrophic program was discontinued and the money transferred to fund the Robert Wood Johnson Foundation program to subsidize insurance for small employers. In the Minnesota case, the program lost funding as part of a general cutback in spending in a budget crunch. While not the only program affected by these cuts, it was vulnerable because of the limited population served.

The Rhode Island Catastrophic Health Insurance Plan was established in 1975. It protects Rhode Island residents against extraordinary costs of catastrophic illness by supplementing their insurance programs. To encourage the continuation of private coverage, deductibles are lower as the quality of insurance an individual has increases. Deductibles for the plan range from \$1,212 for a person with a comprehensive insurance plan to \$12,124 for an uninsured person. The program provided benefits to 526 persons in 1988, the majority of whom had Medicare coverage (70 percent). Only 4 percent of program participants are uninsured. The program participants have an average income of \$15,083 and the major diseases paid for through the program have been heart disease and mental disorders. The program also has a large number of claims for drugs for the elderly.

The state of New Jersey is in the process of establishing a program targeted at families facing catastrophic medical expenses for children 18 years or younger. Called the "Catastrophic Illness in Children Relief Fund," the state plans to finance the fund through a \$1 annual surcharge per employee for all employers subject to the state's unemployment compensation tax. Children that have medical expenses exceeding 30 percent of a family's income up to \$100,000 or 40 percent of the income of a family over \$100,000, and are not covered by another insurance policy, are eligible for reimbursement. The amount of reimbursement will be based on a sliding fee scale according to a family's ability to pay, with an envisioned annual cap per child of \$25,000. Proposed health services eligible for reimbursement include primary care, home



health care, pharmaceuticals, disposable medical supplies, and durable medical equipment.

New York also recently established a catastrophic program on a demonstration basis. Entitled the Pilot Program for Catastrophic Health Insurance, the program is intended to assist people whose health care costs exceed 50 percent of the difference between family income and the imputed public assistance grant -- an amount reflecting the cash value associated with cost of living in the area where the resident resides.

#### c. State requirements for Blue Cross/Blue Shield Plans

In 11 states the Blue Cross/Blue Shield plans offer non-group coverage with open enrollment, no age-adjustment of the premiums, and no exclusions of persons with pre-existing medical conditions. In Virginia and North Carolina open enrollment is required for the plan to maintain its tax-exempt status. Open enrollment provides a greater opportunity for persons who might be regarded as uninsurable to obtain coverage and serves as an alternative to a state high risk pool. No state with Blue Cross/Blue Shield open enrollment policies has a risk pool.

The Blue Shield plan in Pennsylvania conducted a survey in 1986 of non-group subscribers to determine the characteristics of persons who purchase non-group coverage. The plan's survey findings parallel those from national surveys cited earlier. With a median age of 54, the majority of policyholders reported that their health status was in the fair or poor range. Almost 3 percent claimed there was no other insurance available to them. More than one-third of the survey respondents reported selecting the non-group Blue Shield plan because it was the health insurance with which they were most familiar (22 percent reported having a Blue Shield plan for at least 30 years; 50 percent for at least 15 years). Approximately 10 percent of the respondents reported selecting a Blue Shield plan because of the price. The survey found that a majority of the non-group policy holders were employed, and that a large number of low income persons purchase non-group coverage. About 12

percent of non-group subscribers have incomes below \$12,000. Without these policies, many of those who have non-group coverage might be uninsured.

#### **d. State subsidized non-group insurance**

In addition to high-risk pools, catastrophic programs, state requirements for Blue Cross/Blue Shield plans, some states have developed other subsidized non-group insurance. These are described further below.

- **Washington Basic Health Plan.** The Washington Basic Health Plan is a demonstration project designed to provide health care coverage to up to 30,000 uninsured state residents. The plan is available to persons under age 65 who do not qualify for Medicaid and whose incomes do not exceed 200 percent of the poverty level (\$24,200 for a family of four in 1989). Premiums are determined on a sliding scale based on family size and income.
- **New York Individual Subsidy Program.** The New York Individual Subsidy Program is one of two components of the state's Regional Pilot Program for the Uninsured. The Individual Subsidy Program subsidizes premium costs on a sliding scale for uninsured persons with incomes below 200 percent of the federal poverty line. The subsidy is paid directly to an "approved organization or carrier." Uninsured persons with incomes above 200 percent of poverty may buy-in to the program at the full premium cost if they satisfy certain waiting period requirements. However, enrollment of non-subsidized persons may not exceed 25 percent of the total number of subsidized enrollees.
- **Minnesota "Healthspan" Program.** A state-sponsored program that is currently developing an implementation plan, this health insurance program is being designed to bridge the gap between other public insurance programs and the employed. The Healthspan model proposes universal coverage up to 250 percent of the federal poverty level, voluntary participation by the uninsured and employers, managed care through prepaid private insurance, purchase of insurance for the indigent through competitive bidding, and program administration by the state with financing by all levels of government, participating employers, and enrollees on a sliding fee scale.

This survey of activities to expand access to insurance demonstrates considerable efforts in both publicly-funded programs (Medicaid) and private or private/public programs to expand access to employment-based or non-group

insurance. Medicaid expansion has had the largest documentable impact. The impact of some initiatives, such as Blue Cross open enrollment, cannot be documented. The impact of other efforts (risk pools, development of low cost products, direct subsidy : employer and individual insurance) are either small or cannot yet be determined because the programs have not matured.

## H. CONCLUSION

At the beginning of this report, we identified four dimensions of the health financing system -- sufficiency, efficiency, equity, and stability -- against which the need for action to expand access to care can be assessed. As we close this synthesis of information on the performance of the system, we present some conclusions regarding each of these dimensions.

### 1. Sufficiency of Access to Care

Evidence suggests that the uninsured, while not completely excluded from the health care system, do not receive sufficient care. As discussed above, the uninsured have significant shortfalls in utilization of care when compared to the insured. They use fewer hospital and physician services than the insured. A particularly important finding was that uninsured pregnant women had fewer physician visits than insured pregnant women, suggesting that they may be receiving less prenatal care. The uninsured also obtain fewer preventive services than the insured. Reflecting this lower utilization, health care expenditures are lower for the uninsured than the insured. Per capita health expenditures for the uninsured is \$866 compared to \$1,457 for insured persons.

The uninsured report greater barriers to care than the insured. The Robert Wood Johnson Foundation Survey access surveys have consistently found that the uninsured are more likely to report not receiving care when they need it. They are less likely than insured populations to have a regular source of care. The lack of a regular source of care among the uninsured increased 8 percent from 1982 to 1986. Studies have found that persons without a usual



source of care are less likely to use services and may defer care until they are seriously ill.

## 2. Efficiency of Care Received

In this discussion efficiency has two components. One is whether care is being provided in low-cost settings, where appropriate. The second is whether care is being provided at an appropriate stage of a disease, (i.e., soon enough to prevent or avert the need for high cost care. The available information suggests that many aspects of the financing and delivery of care to the uninsured can be made more efficient.

First, the uninsured disproportionately rely on hospital emergency rooms and outpatient departments for their primary care, which are often more costly than private physicians, and in which continuity of care for chronic problems may be limited. The RWJ access surveys consistently show that the uninsured are more likely to rely on a hospital-based provider as their regular source of care than the insured. In addition, an examination of the NMCUES data revealed that uninsured pregnant women have significantly higher hospital outpatient visits than insured women, but significantly lower physician visits. This indicates that these uninsured women are substituting more costly hospital-based care for physician care.

A second source of inefficiency is that the lack of coverage for many primary care services causes many people to wait until they are seriously ill to seek care, perhaps resulting in catastrophic expenses for conditions that could have been treated at an earlier stage. The analysis for the Health Resources and Services Administration and District of Columbia Hospital Association showed higher rates of avoidable hospitalizations among the low-income populations, many of whom are uninsured, than among higher income populations. Further, the study of hypertensive medically indigent adults who were shifted from MediCal coverage to county responsibility found evidence of deferred care among this population.



### 3. Equity in Financing

Equity issues concern whether responsibility for health care financing and delivery for the uninsured is appropriately distributed among providers and payors and whether various segments of the uninsured face the same availability of services. While equity may be "in the eye of the beholder," equity is an issue for providers, payors, and for the uninsured themselves.

Information suggests care for the uninsured is disproportionately provided by public hospitals and clinics and unevenly among private hospitals. On the financing side, private health insurance is largely provided by employers, with large employers assuming greater responsibility than small employers. There is a large group of people, including many low income employed, who obtain insurance by purchasing non-group coverage (which may be inadequate as well as costly) with little or no contribution to the cost of this coverage by government or employers.

Service and insurance availability to the uninsured varies by personal characteristics or place of residence. Public money is earmarked for services to pregnant women and infants and the homeless to a much greater extent than single adult males and goes to services for the elderly to a greater extent than younger people. Some persons who are uninsured in one state would be eligible for Medicaid in another state. Some states provide access to insurance for the uninsurable, others do not. The geographic and other variations in coverage or access to subsidized care are a substantial factor in the interest in expanding insurance coverage.

### 4. Stability of the System

The current health care financing system shows signs of instability that might lead to less access to health care services for the uninsured in the future. Some evidence suggests that access to care has already become more difficult for the uninsured and underinsured.

The number of uninsured has not declined as employment improved. In addition, projected increases in certain populations, such as increases in the number of persons with AIDS, particularly among low income IV drug users, is likely to increase the number of uninsured in the future, and demands by the uninsured for services.

Providers have expressed concerns about their changing reimbursement environment. Increasing competition among providers and more aggressive bargaining and rate-setting by payors has reduced the cushion that helped pay for uncompensated care. Even providers who have a commitment to the poor can become concerned that taking on more than their peers will put them in a financially handicapped position, and that the resources they have used to finance such care will erode.

Finally, federal and state funds for direct services have grown more slowly than other sources of spending, despite increases in the number of uninsured. Financial pressures on employers, providers, and government, coupled with the projected increase in the number of uninsured, may lead to further problems in financing and delivering care to the uninsured and underinsured.

## 5. Implications for Designing Policy Options

Part Two of this report will analyze options for expanding insurance coverage to the uninsured. The findings presented in this synthesis on the nature and extent of the problems of the uninsured have important implications for the design and analysis of options to expand insurance coverage. Principal among them are:

- Options Are not Easily Targeted Only to the Uninsured. Most of the insurance options being considered would affect the insurance coverage of some of the currently insured as well as the uninsured. The diversity of the uninsured population makes it infeasible to target a single approach to the uninsured. Many insured individuals with low and middle incomes who purchase non-group coverage who would likely shift their coverage if they could obtain employer-based insurance or Medicaid. In addition, under

some options many employed persons who obtain coverage from their spouse's plan would be required to obtain insurance from their own employer. These shifts in coverage need to be considered in designing insurance options for the uninsured.

- **Options to Expand Coverage Refinance Much Current Health Care Spending.** As discussed in this report, the cost of closing the utilization gap between the insured and the uninsured would be approximately \$10.7 billion. This represents a one-third increase over current health care spending for the uninsured, and less than 3 percent of overall spending on personal health services. Options to expand insurance coverage involve shifts in financing far in excess of \$10.7 billion. This is because these options refinance care that is currently being paid for as charity care, through direct service grants, through out-of-pocket expenditures or by other insurance. For example, employer mandates would refinance care currently being paid for through non-group insurance, out-of-pocket, public programs, and through the cost shift. Some Medicaid expansions might result in federal and state governments assuming some of the health care spending previously paid for by employers, both as cost shift and if low income insured workers are shifted to Medicaid. A major focus of the debate on options to extend coverage is over how much care is being refinanced and by whom.
- **How Many Are Affected by a Program Can Be Significantly Influenced by Administrative and Programmatic Details.** The number of people an option affects is directly related to the policy decisions regarding eligibility. For example, the number of people affected by a Medicaid expansion option varies significantly depending on the accounting period and the recertification period. Similarly, the reach of employment-based options depends on whether the plan covers part-time and seasonal workers, dependents, and the definition of full-time workers.
- **Employment-Based Approaches Affect Employers that Currently Offer Insurance.** It is difficult to design an employment-based option that targets only those firms that do not offer insurance. Limited tax credits in three states and several RWJ projects have attempted to do this. The difficulty arises because some employers currently offer insurance that does not meet the minimum requirements under the new plan or that does not cover all employees who would be eligible under some proposals. These employers would be required to upgrade their insurance or extend enrollment to additional employees. The factors that determine the extent to which current employers would be affected by a plan include the scope of benefits compared to current benefits, the employer premium share for employees and their dependents, and how part-time and seasonal workers are addressed.



These issues, noted here, will be discussed further in Part Two: An Analysis of Alternative Proposals to Extend Health Insurance.

**PART TWO:**

**ANALYSIS OF ALTERNATIVE PROPSALS  
TO EXTEND HEALTH INSURANCE**





## PART TWO: ANALYSIS OF ALTERNATIVE PROPOSALS TO EXTEND HEALTH INSURANCE

Part Two of this report presents an analysis of options for extending coverage to the uninsured. The options selected attempt to address the major gaps in coverage identified in the synthesis as well as reflect the major options being actively considered in the national policy debate.

While a large number of proposals have been advanced for expanding insurance coverage to the uninsured, only a subset can be analyzed in the project. Many proposals being advanced affect the Medicare and Medicaid programs either because they would directly change these programs or because they affect those who would otherwise be served by the programs. Proposals with both types of impacts are analyzed.

The options analyzed in this report can be grouped into three major categories: 1) Medicaid eligibility expansion and reform; 2) Medicare eligibility expansion and reform; and 3) requirements for employer-based insurance. The specific options analyzed in each category are presented in Exhibit 1. While other options are also being considered, such as efforts to increase employer access to insurance and to assist individuals in obtaining coverage, they were not analyzed in this report. Given the limited time for producing these analyses it was necessary to set priorities among options. The priorities were set using the following criteria: options that are actively being considered by some groups, a mix of public and private sector approaches, and those that are administratively feasible. In several cases recent versions of specific proposals were used as the starting place for constructing an option. As additional options are advanced, it would be possible to analyze them in subsequent work.

In the analysis of these options, we addressed the following questions which frequently emerge in discussions on extending health insurance coverage:

Exhibit 1

Selected Options for Extending Coverage to the Uninsured

Option	Target Population	Eligibility Criteria	Duration of Coverage	Benefits	Financing Issues
<b>A. Medicaid Eligibility Expansion and Reform</b>					
• Mandated Medically Needy programs.	Persons with high-expense illness.	Categorical; 133-1/3 percent of AFDC payment standard.	Current eligibility determination.	Current Medicaid benefits.	Recipient responsible for spenddown portion.
• Uniform minimum benefit standards.	Current Medicaid enrollees.	Current criteria.	Current eligibility determination.	Median state benefit package (Washington State); most comprehensive state benefit package (Minnesota).	States maintain current provider reimbursement rates.
• Mandatory Medicaid coverage for pregnant women and infants.	Pregnant women and infants.	Pregnant women and infants below 185 percent of poverty; no assets; no deductions; continuous eligibility for pregnant women.	Pregnant women covered through pregnancy and 60 days postpartum; infants covered until age 1.	Current Medicaid benefits.	
• National minimum income eligibility level with mandated Medically Needy programs.	Categorically eligible persons below 100 percent of poverty; persons with high-expense illness.	Categorical; asset limit is \$5,000; no deductions. Spenddown eligibility is 133-1/3 percent of AFDC standard.	Monthly income determination; six-month recertification; monthly recertification for medically needy enrollees.	Mandatory Medicaid benefits and Washington State and Minnesota benefits.	State contributes to employer-based insurance premium in lieu of Medicaid if cost-effective.
• National minimum income eligibility level without categorical requirements; mandated Medically Needy programs.	All persons below 100 percent of poverty; persons with high-expense illness.	No categorical requirement; asset limit is \$5,000; no deductions; continuous eligibility for pregnant women.	Same as above.	Same as above.	Same as above.
• Subsidized Medicaid buy-in.	Persons below 185 percent of poverty.	No categorical requirement; asset limit is \$5,000; no deductions.	Monthly income determination; six-month recertification.	Mandatory Medicaid benefits plus mental health and EPSDT benefits.	Available on sliding scale premium; cost sharing for persons above poverty.

**Exhibit 1**  
**(continued)**

**Options for Extending Coverage to the Uninsured**

Option	Target Population	Eligibility Criteria	Duration of Coverage	Benefits	Financing Issues
<p>A. Illustrative Medicaid option including national minimum income eligibility level without categorical requirements, mandated Medicaid for pregnant women and infants with incomes up to 185 percent of poverty.</p>	All persons below 100 percent of poverty; persons with high-expense illness; pregnant women and infants.	No categorical requirement; asset limit is \$5,000 except for pregnant women; no deductions; continuous eligibility for pregnant women.	Monthly income; six-month recertification except pregnant women who are covered through 60 days postpartum and medically needy persons who are recertified monthly.		State contributes to employer-based insurance premium in lieu of Medicaid if cost effective.
<p>B. Medicare Eligibility Expansion and Reform: Eliminate Waiting Period for SSDI</p>	Disabled persons	Disabled persons receiving cash assistance under the Social Security Disability Insurance Program	--	Current Medicare benefits.	
<p>C. Requirements for Employer-based Insurance</p> <p>• Employer mandate, specified benefits</p>	Employed uninsured and their dependents	Employees working at least 17.5 hours per week and their dependents.	<p>Specified basic benefits. Includes inpatient and outpatient hospital coverage, inpatient and outpatient physician services, prenatal care, well-baby care.</p> <p>Catastrophic limit of \$3,000 per family. No exclusions for persons with pre-existing conditions.</p>	<p>Employer and employee share cost of premium. No cost sharing for persons below 125 percent of the minimum wage for employer-based. Employer pays at least 50 percent of premium for employees working between 17.5 and 25 hours per week; at least 80 percent for persons working 25 or more hours. No cost sharing for prenatal and well-baby care.</p>	



Exhibit 1  
(continued)

Options for Extending Coverage to the Uninsured

Option	Target Population	Eligibility Criteria	Duration of Coverage	Benefits	Financing Issues
• Employer mandate catastrophic benefits	Employed uninsured and their dependents	Same as above.		Catastrophic benefits only: outpatient hospital coverage, inpatient and outpatient physician services, laboratory and x-ray services, and prescription drugs.	Same as above except the deductible is increased to a maximum of \$2,000 per person and \$5,000 per family.
• Employer mandate with Medicaid expansions	All uninsured.	Employees working at least 17.5 hours per week and their dependents. Medicaid is available for all other uninsured persons. Full coverage for persons below 100 percent of poverty, buy-in for persons between 100 and 185 percent of poverty.		Specified basic benefits. No exclusions for persons with pre-existing conditions.	Same as employer mandate with specific benefits plus no cost sharing for persons below 100 percent of poverty for Medicaid.
• Pay or Play Approach	All uninsured.	Employees working at least 25 hours per week and their dependents covered by employers; all persons not covered through employment or by non-group plans must enroll in public fund.	Catastrophic limit of \$1,000 per person and \$3,000 per family.	Basic benefits; no exclusions for persons with pre-existing conditions.	Employers and employees share premium. Cost sharing. No premium or cost sharing for persons below 150 percent of poverty.

- What is the impact on the total number of uninsured persons?
- How will insurance coverage change if this proposal is implemented? This is broader than the change in the number of uninsured. The following types of changes in insurance status were examined:
  - From uninsured to insured.
  - Shifts among insurance coverage.
  - Improvements or supplements to existing coverage.
- What is the cost of the option? What are the federal and state costs for Medicaid expansion? What are the employer costs for employer mandates?
- How will the utilization of health services change? Which health care services will experience increases (or decreases)?
- How will the sources of payment for care change? As a result of these proposals, the source of payment for services can change for both new services and services previously received among both the formerly uninsured and the formerly insured whose coverage has changed.
- Which individuals and families experience the greatest change in their health expenditures or health care use?
- How will the proposal affect the health care delivery system? For example:
  - How will the level of uncompensated care change?
  - How will the sources of care shift?
- What will be the impact of employment-based options on employment and wages?
- How target efficient is the proposal?
- What are the administrative and design issues in implementing this proposal? What kind of administrative burden does the proposal impose on state or federal government, on insurers, or on employers?

Much of the analysis of these options was done using the Lewin/ICF Health Benefits Simulation Model (HBSM). This model has been developed to permit analysis of national and state proposals to restructure the financing of health care. The model includes information on the number of uninsured and insured, and for the insured, their sources of coverage. It also includes

demographic information on these populations, data on health care expenditures by age, sex, income, and insurance status, and out-of-pocket, employer, and government contributions to the financing of care. Alternative proposals can be modeled and their impact on the number of uninsured, the sources of insurance coverage, changes in health use and health expenditures, and sources of funding for care can be analyzed.

To allow this analysis, we have integrated data from three sources into HBSM. The March 1988 Current Population Survey (CPS) provides data on the distribution of persons by type of health insurance, income, employment, and other demographic detail. The 1980 National Medical Care Utilization and Expenditure Survey (NMCUES) provides extensive information on persons and households concerning health status, health care utilization, including the condition treated, place of treatment, total charge, and amounts paid by various sources. The NMCUES expenditure data have been adjusted using the HCFA National Health Accounts, the Health Interview Survey, and AHA data to reflect changes in utilization and health costs since 1980. The Small Business Administration Employer Health Plan Data Base provides detailed information on health plans of a representative sample of small and large firms. Individuals in the CPS-NMCUES household data who are covered by an employer plan are statistically matched with one of the 846 employer plans in the SBA employer health plan data base to permit analysis of the impact of benefits, cost sharing provisions, and eligibility requirements of proposals on employers who currently provide insurance.

HBSM estimates the number and characteristics of persons who become covered or change types of coverage under various proposals to expand coverage. It also estimates the increase in utilization which occurs as coverage is extended to the uninsured. Program costs are estimated by determining the allowable reimbursement for each health care service reported by newly insured persons using the coverage and cost sharing rules specified in the policy option.



The HBSM approach is flexible and has been adapted to analyze a wide range of options and multiple variations on single options. The results have been corroborated by independent actuaries. A detailed description of HBSM and the assumptions used to analyze the options in this report are presented in Appendix A, a separate volume to this report.

Before the results of the analysis are presented, each option is described in detail. The assumptions used in analyzing the options are also specified. These assumptions are of two types: 1) programmatic descriptors (the choice of which can have substantial impacts on eligibility and costs); and 2) assumptions about how individuals and firms will respond to the choices provided by the option. Where possible, we have used available research or data in defining the assumptions. In some cases, where there is limited current empirical basis for selecting assumptions, we conduct sensitivity tests on these assumptions to determine the impact of alternative responses on the estimates. Most assumptions were chosen because they represented a mid-range or high probability estimate; in some cases, where no basis for selecting an intermediate assumption existed, outer bound assumptions were used.

The report is organized into five sections. Section A presents the description and results of the Medicaid expansion; Section B, the Medicare expansion; Section C, the employer mandate options. These three sections focus on two issues: the number of people affected and the cost of the option. Section D compares the options in terms of their impact on the number of uninsured, health care utilization, sources of payment, family health expenditures, health care delivery system, employment and wages, and target efficiency. Finally, Section E discusses administrative feasibility issues.

#### A. MEDICAID ELIGIBILITY EXPANSION AND REFORM

Expanding the Medicaid program represents a major approach to extending coverage to the uninsured. In fact, over the past four years, Congress has passed a number of expansions to the Medicaid program. These



have focused on expanding eligibility for certain population groups, such as pregnant women and children, the low-income elderly and disabled.

Medicaid expansion can be designed in a variety of ways, with policy decisions required along six dimensions:

- **Categories of People to Be Covered.** Medicaid coverage is currently limited to certain defined categories of people based on family composition and demographic characteristics. Persons not in those groups are not eligible regardless of their income. Options to expand Medicaid have ranged from incremental expansions of the categories to the elimination of categorical requirements. In this analysis we examine options for the current categorically eligible populations, as well as options that eliminate the categorical requirements altogether.
- **Income.** In addition to personal characteristics, income is the other major determinant of Medicaid eligibility. Most of the options considered specify a uniform Medicaid income standard that is tied to a percentage of the federal poverty level. These options can be varied by selecting different income levels (e.g., 100 or 150 percent of poverty) and by applying the income level to certain groups of Medicaid eligibles (e.g., pregnant women). Another policy consideration is whether the option allows persons to pay a premium to "buy into" Medicaid. We examine options that create a uniform eligibility level at 75, 100, and 130 percent of poverty and a Medicaid buy-in for persons with incomes below 185 percent of poverty.

Another dimension of income is the accounting period over which income is reviewed in determining eligibility. Looking at income for only the previous month will result in more people being qualified for eligibility than considering income over the previous six months or year.

- **Other Eligibility Factors.** Two other factors used in determining Medicaid eligibility need to be considered in designing options: 1) assets and 2) deductions. To qualify for Medicaid coverage, individuals must have limited assets in addition to being low income. However, they may deduct some expenses, such as child care from their income. Both of these eligibility criteria apply more to eligibility for cash assistance than medical assistance and in designing Medicaid expansion options, they could be modified or eliminated entirely. In this analysis, because of data limitations, we have used an asset eligibility limit of \$5,000 and not considered deductions, except for medical expenses considered in medically needy spend down.

- **Benefits.** The major decisions regarding benefits are whether to establish a uniform benefit package across all states and what should be included in the uniform benefits. Several options were modelled.
- **Spend Down Provisions.** Currently 36 states have medically needy programs which allow persons to spend down to gain Medicaid coverage. Spend down refers to the process by which individuals/families with incomes or assets in excess of the specified limits can become eligible for Medicaid if the medical expenses they incur are large enough. Options can mandate medically needy programs in all states. They can also set the medically needy eligibility level at uniform levels. Several options modelled include such specifications.
- **Duration of Coverage.** Closely related to the accounting period for eligibility (discussed under Income above) is the period over which eligibility is extended or certified. Typically in cash assistance programs, a one-month accounting period and one-month certification are used. For SSI and non-cash Medicaid recipients some states certify coverage for longer periods. Welfare reform has also led to a lengthening of the certification periods. Longer periods of certification result in higher numbers of insured. For most options, we have assumed a six-month prospective certification.

The Medicaid expansion options analyzed as part of this study incorporate specific decisions about each of these policy variables. We analyzed six options for Medicaid eligibility expansion: five distinct "stand alone" proposals and one "illustrative Medicaid expansion package" which integrates a number of the options into a single plan. The five "stand alone" options, organized from least to most expansive, are:

- Mandatory medically needy programs for non-institutionalized persons in all states.
- Standardized state Medicaid benefit packages using:
  - a "median" state benefit package (Washington model)
  - the "most comprehensive" benefit package (Minnesota model).
- Medicaid expansion for pregnant women and infants with incomes up to 185 percent of poverty.
- Selected national minimum income eligibility levels assuming:
  - categorical eligibility is retained
  - categorical eligibility is eliminated.

- Medicaid buy-in for non-institutionalized persons with incomes below 185 percent of the poverty level.

Under the sixth option, the "illustrative Medicaid expansion package," three of the options analyzed above are combined: 1) the eligibility level is raised to 100 percent of poverty with categorical requirements eliminated; 2) medically needy programs are established in all states; and 3) coverage is extended to pregnant women and infants with incomes up to 185 percent of poverty.

For each option we assume that the asset limit for Medicaid eligibility is increased to \$5,000, eligibility is based on monthly income, eligibility is certified every six months, and eligibility for unemployed parents is permitted in all states. Two exceptions to this are: 1) for pregnant women and infants, no asset test is applied and eligibility is continuous through 60 days postpartum; 2) for the spend-down population, eligibility is based on monthly income and is certified monthly.

Not all persons who are eligible for Medicaid enroll. Each option requires an assumption about how many of those newly eligible for Medicaid would enroll. (The cost and impact of Medicaid expansion proposals are heavily influenced by the enrollment rate.) Based on the experience with the current program, not all of those who are eligible will take advantage of expansions. Currently 32.2 million persons are eligible for Medicaid with 23.3 million persons (72 percent) actually enrolled in the program.

We assume that patterns of enrollment among newly eligible persons would be similar to patterns observed in the current program. Analysis of enrollment versus eligibility in the NMCUES data base shows that enrollment in Medicaid is highest for persons reporting themselves to be in poor health and lowest for healthy persons and persons who are employed or have insurance from other sources. Enrollment declines as income increases. We have used a multifactor model that incorporates income, health status, presence of other insurance, and employment into the enrollment decisions of each eligible in



the data base. (This is described in the Technical Appendix.) On average this model estimates that 63 percent of the newly eligible would enroll in Medicaid. This is lower than average current enrollment rates because the new enrollees tend to have higher incomes than current enrollees.

The remainder of this section presents the analysis of the five Medicaid expansion options and the illustrative Medicaid expansion package.

# **1. Mandated Medically Needy Programs for Non-Institutionalized Persons in All States**

The uninsured as well as a large number of the insured are at risk for catastrophic health expenses. Establishing medically needy programs as part of state Medicaid programs is one way of protecting certain categories of persons from catastrophic expenses. The medically needy program allows persons who meet the categorical eligibility criteria for Medicaid but whose income and/or assets are above the Medicaid eligibility level to become eligible for Medicaid once they incur substantial medical expenses that bring their income below a certain percentage (up to 133-1/3 percent) of the state's AFDC payment standard. This process is called spend down. The ability to "spend down" helps families preserve some resources and not become impoverished due to high medical expenses. Where a state has established a medically needy level above the AFDC level, some persons become immediately eligible on the basis of their income and categorical status. For example, if the medically needy level is at 90 percent of poverty and the AFDC level is at 70 percent of poverty, those persons with incomes between 70 and 90 percent would be eligible for Medicaid without cash assistance.

Medically needy programs are currently optional to the states. To date, 36 states have established medically needy programs. This analysis examines the impact of requiring all states to establish medically needy programs with eligibility levels set at 133-1/3 percent of the state's AFDC level. Exhibit 2 presents the assumptions used to analyze this option. Eligibility through spend down would be limited to categorically eligible



## Exhibit 2

### Mandated Medically Needy Programs

Target Population: Persons with high-expense illness.

#### Eligibility Criteria:

- Categorical eligibility: Yes
- Assets: Current provisions.
- Deductions: Current provisions.
- Spenddown provisions: Spenddown liability is 133-1/3 percent of the state's AFDC payment standard.

Duration of Coverage: Current eligibility determination.

Benefits: Current Medicaid benefits.

#### Financing Issues:

- Cost sharing: None.

#### Modeling Assumptions:

- Enrollment: Persons enroll at current rates for Medically Needy programs.

persons, and would require incurring medical expenses that bring income below 133-1/3 percent of the state's AFDC payment standard or 100 percent of poverty for pregnant women and infants and the elderly and disabled. If a state's medically needy level is currently over 100 percent of poverty, as in California and Vermont, the program is unchanged.

**a. Number of persons affected**

Under a mandatory medically needy program an additional 1.7 million persons would enroll in Medicaid on an average monthly basis (Table 33). Over 80 percent of the new enrollees are income eligible; 300,000 are enrolled through spenddown. The total number of people enrolled in Medically Needy programs would increase by 44 percent. The large increase in the number of Medically Needy persons is attributed to new programs being established in 14 states as well as requiring all states to increase their Medically Needy level to 133-1/3 percent of their AFDC payment standard. Currently only a few states have Medically Needy eligibility levels at 133-1/3 percent of their AFDC level for all family sizes.

**b. Program costs**

The total annual program costs are estimated to be \$2.2 billion. The income spenddown enrollees, while representing one-fifth of new enrollees, account for almost one-third of program costs (Table 33). This group is by definition more costly, having been brought into the program in part by their health care expenses.

Table 33

New Enrollment and Program Costs Under Mandatory Medically  
Needy Policy Option for Non-institutionalized Persons<sup>a/</sup>

	Average Monthly New Enrollment (in millions)	Annual Program Costs (in billions) <sup>b/</sup>		
		Total Costs	Federal Share	State Share
Income Eligible	1.4	\$1.5	\$0.9	\$0.6
Income Spend-down	0.3	0.7	0.4	0.3
Total	1.7	\$2.2	\$1.3	\$0.9

<sup>a/</sup> Assumes eligibility is provided to categorical groups only.

<sup>b/</sup> Includes benefit costs and administration.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

## 2. Standardized State Medicaid Benefits Packages

Federal law currently mandates certain basic services and allows states discretion in supplementing these basic services with optional services. States vary in which optional services they provide and some limit access to basic services by restricting the number of days or visits covered. As a result, Medicaid recipients in some states have access to a more comprehensive benefit package than Medicaid recipients in other states. It has been suggested that the Medicaid benefit package be standardized such that all recipients have access to the same services.

While creating a uniform benefit package for all states would eliminate variations in enrollee access to some services across states, it would be difficult to achieve. Without adopting the most comprehensive state benefit package as the standard, which would be prohibitively expensive, some states would be required to eliminate benefits, which would be politically difficult. We analyzed the impact of raising the minimum Medicaid benefits for non-institutionalized persons under two alternative benefit packages. This analysis was not done using HBSM, but used the methods described by Kenneth Thorpe of the Harvard School of Public Health (Thorpe, 1989). The first model would raise the minimum benefit floor from its current level to a level representing the "average" state (allowing states with more comprehensive benefits than this to continue to provide their extensive benefits). The second model would establish a minimum benefit package at the "most comprehensive" level, as a uniform level of benefits required in all states (Exhibit 3).

The two alternative benefits packages are based on Medicaid programs in Washington State and Minnesota (Exhibit 4). The Washington program was used as a model for a moderate benefit package since it currently represents a median in comprehensiveness among state Medicaid programs. Two other states have similar plans, while 25 states have programs with more comprehensive benefits packages. Establishing the Washington benefit package as the national standard affects 22 states. The Minnesota benefit package represents the most comprehensive Medicaid plan in the country, with no limits on



### Exhibit 3

#### Uniform Federal Minimum Benefit Standards

Target Population: Medicaid enrollees.

Eligibility Criteria:

- Categorical eligibility: Yes
- Assets: Same as currently in place.
- Deductions: Same as currently in place.
- Spenddown provisions: Current provisions.

Duration of Coverage: Current eligibility determination.

Benefits: Model with 1) moderate state benefit package (e.g., Washington State); 2) comprehensive state benefit package (e.g., Minnesota).

Financing Issues:

- Cost sharing: None.

Modeling assumptions:

- Enrollment: Assume no impact on Medicaid enrollment.

## Exhibit 4

### Differences in Selected Benefits Minnesota and Washington State Medicaid Programs

Type of Benefit	Minnesota	Washington
Physician Services	<ul style="list-style-type: none"> <li>▪ Certain services not covered</li> <li>▪ No limits on visits.</li> <li>▪ No limits or prior authorization required for psychiatric visits.</li> </ul>	<ul style="list-style-type: none"> <li>▪ All services covered</li> <li>▪ Visits in hospitals limited to 1 per day.</li> <li>▪ Visits in long-term care facilities limited to 24 per year.</li> <li>▪ Limited to 1 hour per month. Prior authorization required.</li> </ul>
Home Health Services	<ul style="list-style-type: none"> <li>▪ No limits on home health visits.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Limits on part-time nursing, home care.</li> </ul>
Hospital Services	<ul style="list-style-type: none"> <li>▪ Prior authorization for certain procedures.</li> <li>▪ Limits on hospital coverage.*</li> <li>▪ No limits on inpatient days.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Prior authorization for all elective surgery.</li> <li>▪ No limits on hospital coverage.</li> <li>▪ Limits on inpatient days.</li> </ul>
Maternal and Child	<ul style="list-style-type: none"> <li>▪ Enriched Benefits: risk assessment, case management, home visiting, health education, childbirth education, nutrition.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Generous EPSDT visit coverage.</li> </ul>

\* Refers to any other limitation in coverage, e.g., limits on "experimental" treatments, second opinion requirements, preadmission requirements, etc.

Source: Provided by Kenneth Thorpe, Harvard School of Public Health. Health Care Financing Administration, Analysis of State Program Characteristics 1986. Baltimore, MD: Office of the Actuary, August 1987; Children's Defense Fund, Campaign Notes, November 1988.

physician visits or inpatient hospital days. Instituting this plan as the national standard would require 49 states to improve their Medicaid benefits.

**a. Number of people affected**

Such a program will affect only persons currently enrolled in the program and is not likely to expand enrollment.

**b. Program costs**

Requiring 22 states to improve their benefits to the level of the Washington State benefit package would increase program costs by \$4.8 billion (12 percent). In contrast, were all states to adopt the Minnesota Medicaid benefits, program costs would increase by 64 percent or \$24.9 billion (Table 34). Part of the reason for this is that the largest Medicaid programs (e.g., California and New York) would not be affected by adopting the Washington benefit package, but would be required to upgrade their plans to conform to the Minnesota benefit package. The cost of expanding benefits in all states should be considered an outer bound estimate because, if states were required to adopt the Minnesota benefit package, they would be likely to reduce provider reimbursement rates, resulting in a somewhat lower increase in program costs.

**3. Medicaid Expansion for Pregnant Women and Infants up to 185 Percent of Poverty**

The Medicare Catastrophic Coverage Act of 1988 mandated that states extend Medicaid coverage to pregnant women and infants in families with incomes below 100 percent of poverty. This has since been increased to 133-1/3 percent of poverty under OBRA 1989. States currently have the option of providing Medicaid coverage to pregnant women and infants up to 185 percent of poverty. As of July 1989, 15 states had adopted this higher threshold, with an additional 5 states opting for an eligibility level between 100 and 185 percent of poverty. One option that is being considered would require states

Table 34

Estimated Impact of Standardizing State Medicaid Benefit Packages Under  
Two Alternative Benefit Package Models in 1989<sup>a/</sup>  
(in billions)

	<u>Cost</u>		
	<u>Total Costs</u>	<u>Federal Share</u>	<u>State Share</u>
Original state benefit package	39.1	21.6	17.5
Washington model	4.8	2.6	2.2
Minnesota model	24.9	13.8	11.1

<sup>a/</sup> Excludes persons in institutions.

Source: Benefit calculations provided by Kenneth Thorpe of the Harvard School of Public Health.



to raise the eligibility level for pregnant women and infants to 185 percent of poverty.

Analysis of this option is straightforward. Exhibit 5 presents the assumptions used for the analysis.

**a. Number of persons affected**

Approximately 2.2 million pregnant women and infants would be expected to enroll in Medicaid over the course of a year; the average monthly enrollment is 1.9 million (Table 35). Slightly more infants than pregnant women are estimated to be eligible and enrolled in the program. Reasons for this are twofold. First, a small proportion of women have multiple births. An analysis of the cost of enacting the SOBRA expansions in Colorado found 1.09 infants per pregnant woman (Butler). Second, many women who are employed throughout their pregnancies earn incomes higher than 185 percent of poverty, rendering them ineligible for Medicaid coverage. Upon delivery, however, some of these women will discontinue employment and their monthly incomes will drop below the 185 percent of poverty threshold, enabling them to enroll their infants -- but not themselves -- in Medicaid.

**b. Program costs**

The average annual cost of the program is \$1.2 billion (Table 35). Total costs for pregnant women account for 67 percent of the total program costs although they represent slightly less than one-half of the new enrollees. This is largely because all the women who enroll have substantial costs due to their pregnancy; most of the infants are healthy, experiencing only the costs associated with well-child care.

**4. Selected National Minimum Income Eligibility Levels**

States have considerable flexibility in setting their Medicaid eligibility policies. Because of this, where people live makes a difference

## Exhibit 5

### Mandatory Medicaid Coverage for Pregnant Women and Infants Below 185 Percent of Poverty

Target Population:	Pregnant women and infants with incomes below 185 percent of poverty.
Eligibility Criteria:	
▪ Categorical eligibility:	Applies only to pregnant women and infants.
▪ Assets:	Asset requirements are waived.
▪ Deductions:	None.
Duration of Coverage:	Pregnant women: through pregnancy and 60 days postpartum.  Infants: until one year of age.
Benefits:	Current Medicaid benefits.
Financing Issues:	
▪ Cost sharing:	None.
Modeling Assumptions:	
▪ Enrollment:	No one with employment-based insurance drops coverage.  All pregnant women and infants who are eligible for Medicaid will drop non-group coverage.  Newly eligible pregnant women and infants enroll at current rates for these population groups.
Phase-in Schedule:*	75 percent of poverty - 1989 100 percent of poverty - 1990 125 percent of poverty - 1991 150 percent of poverty - 1992 175 percent of poverty - 1993 185 percent of poverty - 1994  Modeled at 75 percent (1st year) and 185 percent in 1989 dollars (full phase-in).

\* Since this analysis was conducted, states are now required to cover all pregnant women and infants with incomes below 133 percent of poverty by 1990. This would accelerate the phase-in schedule above.

Table 35

New Enrollment and Program Costs Under Medicaid Expansion for Pregnant Women and Infants Up to 185 Percent of Poverty<sup>a/</sup>

Policy Option	Total New Enrollment Under Policy (in millions)			Annual Program Costs Under Policy Options <sup>b/</sup> (in billions)		
	Eligible in Year	Ever Enrolled in Year	Average Monthly Enrollment	Total Cost	Federal Share	State Share
Pregnant Women	1.5	1.0	0.8	\$0.8	\$0.5	\$0.3
Infants	1.6	1.2	0.8	0.4	0.2	0.2
Total	3.1	2.2	1.9	1.2	0.7	0.5

<sup>a/</sup> The assets test is eliminated and eligibility is assumed to be certified through 60 days postpartum.

<sup>b/</sup> Includes benefit costs and administration.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

in whether they are eligible for Medicaid. Medicaid eligibility varies by state: the eligibility level as a percent of poverty ranges from 14 percent in Alabama to 106 percent in California with a nationwide average of about 60 percent of poverty. This variation has a direct impact on the number of people who are uninsured in each state.

Until recently, Medicaid eligibility was largely linked to eligibility for cash assistance. Receipt of public assistance qualified individuals as categorically eligible for Medicaid. Other non-categorically eligible persons could qualify for a medical assistance program at the state's discretion, and at the state's expense.<sup>1</sup>

A number of the options proposed to expand insurance coverage to the uninsured have focused on creating a national minimum income eligibility level for Medicaid. We will analyze two major variations on this option. The first option sets the Medicaid eligibility level at 100 percent of the federal poverty level (\$12,100 for a family of four) for all persons who are currently categorically eligible for Medicaid. The second option eliminates the categorical requirement entirely and allows all persons with incomes below 100 percent of poverty to obtain Medicaid. Both of these options are also analyzed at 75 and 130 percent of poverty (\$9,075 and \$18,150, respectively, for a family of four) to examine the sensitivity of the results to different eligibility levels. States with eligibility levels above these levels are assumed to maintain their levels. Exhibits 6 and 7 present the assumptions used for these analysis.

With regard to benefits, we analyze all states with their current Medicaid benefits, with an average state benefit package (e.g., Washington State), and with the most comprehensive benefit package (Minnesota). Those

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<sup>1</sup> Recent changes in federal law under SOBRA and the Medicare Catastrophic Act have weakened the link between eligibility for Medicaid and cash assistance by extending Medicaid coverage to pregnant women and young children and the elderly and disabled with incomes below the poverty level.



## Exhibit 6

### Selected National Minimum Income Eligibility Levels

Target Population:	Persons with incomes below 100 percent of poverty (all model at 75 and 130 percent of poverty) and persons with incomes above these amounts who incur large medical expenses.
Eligibility Criteria:	
▪ Categorical eligibility:	Yes
▪ Assets:	Asset eligibility limit is raised to \$5,000 nationwide
▪ Deductions:	Unlike current AFDC eligibility, deductions for work expenses, child care, and other expenses, not taken into account in the model.
▪ Spenddown provisions:	Mandate Medically Needy in all states; spenddown liability is 133-1/3 percent of the state's AFDC standard.
Duration of Coverage:	Monthly income eligibility determination; six-month recertification except for spenddown enrollees which are recertified monthly.
Benefits:	Mandatory Medicaid benefits; also model with Washington State and Minnesota benefit packages as the uniform benefit package.
Financing Issues:	
▪ Cost sharing:	None.
▪ Other:	States pay employee's share of the premium for employment-based coverage if it is less than Medicaid coverage.
Modeling Assumptions:	
▪ Enrollment:	Does not change among currently eligible.  No one who currently has employer-based coverage enrolls in Medicaid.  Among other newly eligible, current enrollment/eligibility ratio is used varied by age, sex, health status, employment and income.

## Exhibit 7

### Selected National Minimum Income Eligibility Levels Without Categorical Requirements

Target Population:	Persons with incomes below 100 percent of poverty (also model at 75 and 130 percent of poverty) and persons with incomes above these amounts who incur large medical expenses.
Eligibility Criteria:	
▪ Categorical eligibility:	No
▪ Assets:	Asset eligibility limit is raised to \$5,000 nationwide.
▪ Deductions:	Unlike current AFDC eligibility, no deductions would be permitted for work expenses, child care, and other expenses.
▪ Spenddown provisions:	Medically Needy program mandated in all states; spenddown liability is 133-1/3 percent of the state's AFDC standard.
Duration of Coverage:	Monthly income eligibility determination; six-month recertification except for spenddown enrollees which are recertified monthly.
Benefits:	Mandatory Medicaid benefits; also model with Washington State and Minnesota benefit packages as the uniform benefit package.
Financing Issues:	
▪ Cost sharing:	None.
▪ Other:	States pay the employee's share of the premium for employment-based coverage if it is less than Medicaid coverage.
Modeling Assumptions:	
▪ Enrollment:	Does not change among current categorically eligible.  No one who currently has employer-based coverage enrolls in Medicaid.  Among other newly eligible, current enrollment/eligibility ratio is used varied by age, sex, health status, employment, and income.

states that currently have more comprehensive benefits than the average benefit package would retain their current packages.

To model these options, it is necessary to develop assumptions about the likely enrollment rates in Medicaid at the new eligibility levels. We make three assumptions: 1) those currently eligible but not enrolled do not enroll; 2) among the newly eligible, persons enroll at the rate predicted by our model based on their age, sex, health status, employment, and income characteristics; and 3) no one who currently has employer-based coverage enrolls in Medicaid.

a. Number of people affected

Raising the Medicaid eligibility levels with categorical eligibility requirements retained would result in 3.8 million persons enrolling at 75 percent of poverty in a year and 6.7 million persons enrolling at 130 percent of poverty (Table 36). As would be expected, the number of newly eligible persons increases as the eligibility level increases.

Many more people would enroll in Medicaid moving from current eligibility levels to 75 percent of poverty than from 75 percent to 130 percent of poverty. This is largely because Medicaid enrollment rates decrease as income increases. Some persons at higher income levels may obtain employer-based insurance and choose not to enroll in Medicaid.

At all eligibility levels, the number of persons ever enrolled in a year would exceed the average monthly enrollment. For example, at 100 percent of poverty the number of persons ever enrolled in a year would be 21 percent higher (.9 million persons) than the average monthly enrollment. This is because many persons are eligible for Medicaid for only part of the year (e.g., when they are unemployed). Thus program turnover keeps the average monthly enrollment below the total number in the program at some point during the year.

Table 36

New Enrollment Under Selected National Minimum Income Eligibility Levels in 1989<sup>a/</sup>

Policy Option <sup>b/</sup>	Total New Enrollment Under Policy (in millions)			Annual Program Costs Under Policy Options <sup>c/</sup> (in billions)		
	Eligible in Year	Ever Enrolled in Year	Average Monthly Enrollment	Total Cost	Federal Share	State Share
Eligibility Limit Increased to:						
75 Percent of Poverty Line	5.9	3.8	2.7	\$ 1.9	\$1.3	\$0.6
100 Percent of Poverty Line	7.6	5.1	4.2	3.6	2.3	1.3
130 Percent of Poverty Line	10.2	6.7	5.5	4.4	2.7	1.7

<sup>a/</sup> Excludes persons in institutions.<sup>b/</sup> In all policy options, it is assumed that categorical eligibility criteria are retained, the asset limit is increased to \$5,000, eligibility is certified for six-month periods, medically needy programs are implemented in all states, and eligibility for unemployed parents is permitted in all states.<sup>c/</sup> Includes benefit costs and administrative expenses.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



If categorical eligibility is eliminated, enrollment in the program would more than triple from the levels with categorical eligibility at all selected eligibility levels (Table 37). At an eligibility level of 100 percent of poverty, an additional 17.5 million previously ineligible non-categorical persons become eligible for Medicaid, of whom an estimated 9.2 million would enroll in an average month. This increase in eligibility and enrollment is due largely to the new eligibility of single persons, childless couples, and intact families. Also, under the program, we have assumed that all states would enact a medically needy program and eligibility for this would also not be categorical. Thus, in addition to the persons added to the program by raised income standards, persons are also added through the creation of new medically needy programs.

Some employers might drop their insurance coverage if Medicaid coverage became available to their workers. This is unlikely at an eligibility level of 75 percent of poverty but could occur at an eligibility level of 130 percent of poverty with categorical requirements eliminated. In this analysis we have assumed that employers do not drop their coverage nor do they encourage workers to enroll in Medicaid.

#### b. Program costs

Tables 36 and 37 also present the annual program costs for Medicaid eligibility expansions when categorical eligibility requirements are retained and when they are eliminated, respectively. Program costs would rise proportionally with enrollment increases. Dropping categorical eligibility restrictions would result in a five-fold increase in program costs at an eligibility level of 75 percent of poverty and a four-fold increase in program costs at eligibility levels of 100 and 130 percent of poverty when compared to retaining categorical eligibility.

Table 37

**New Enrollment and Program Costs Under Selected National Minimum Income Eligibility Levels  
with Categorical Eligibility Criteria Eliminated in 1989<sup>a/</sup>**

Policy Option b/	Total New Enrollment Under Policy (in millions)			Annual Program Costs Under Policy Options <sup>c/</sup> (in billions)		
	Eligible in Year	Ever Enrolled in Year	Average Monthly Enrollment	Total Cost	Federal Share	State Share
Eligibility Limit Increased to:						
75 Percent of Poverty Line	20.0	12.4	9.3	\$10.1	\$ 6.1	\$ 4.0
100 Percent of Poverty Line	25.1	16.6	13.4	14.3	8.5	5.8
130 Percent of Poverty Line	34.3	22.0	18.3	17.7	10.5	7.2

a/ Excludes persons in institutions.

b/ In all policy options, it is assumed that Medicaid eligibility is decoupled from public assistance eligibility, the asset eligibility limit is increased to \$5,000, eligibility is certified for six-month periods, and medically needy programs are implemented in all states.

c/ Includes benefit payments and administrative costs.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Particularly striking is the high cost of newly eligible persons under spenddown when categorical requirements are eliminated (Table 38).<sup>2</sup> While benefit costs for income eligible persons would more than triple when categorical requirements are eliminated at eligibility levels of 100 and 130 percent of poverty, the benefit costs of persons eligible through spenddown are over five times higher. This is because a large number of persons would be affected since mandating states to establish medically needy programs without categorical requirements requires all states to modify their programs, while the same requirement with categorical eligibility affects only the 14 states without medically needy programs.

Also, current Medicaid enrollees would benefit from raising the eligibility level because they would be required to spenddown less to become eligible under the Medically Needy program. Table 38 also presents the cost of more rapid spenddown among current enrollees.

Raising Medicaid eligibility levels was also analyzed assuming states adopt the Washington State and Minnesota benefit packages. Total costs increase by about 11 percent under the Washington State benefit package and 63 percent under the Minnesota benefit package (Table 39).

#### c. Variations in enrollment assumptions

Actual enrollment under the Medicaid expansion options could differ from patterns observed in the current program. Variations in enrollment could result in higher or lower cost estimates than those presented above. To illustrate the sensitivity of our estimates to enrollment behavior, we present estimates of enrollment and program costs under two alternative enrollment assumptions. As an upper bound estimate we assume that all eligible persons

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<sup>2</sup> We have assumed in this analysis that medically needy thresholds would rise as the level of income eligibility for the program rises. This need not be the case. In the recent SOBRA expansion, medically needy levels remained the same as eligibility increased for certain population groups.

Table 38

**Detailed Analysis of Program Costs Under Selected National Income Eligibility Levels With and Without Categorical Eligibility**  
(in millions)

	Benefits to Income Eligible Enrollees	Income Spenddown		Total Benefits	Administrative Costs	Total Cost	Federal Share	State Share
		Current Enrollees (More Rapid Spenddown)	Newly Eligible					
Retain Categorical Criteria:								
75 Percent Poverty	\$ 1,172	\$ 74	\$ 616	\$ 1,862	\$ 80	\$ 1,942	\$ 1,285	\$ 657
100 Percent Poverty	2,621	132	658	3,411	147	3,558	2,242	1,316
130 Percent Poverty	3,340	201	701	4,242	182	4,424	2,755	1,669
Eliminate Categorical Criteria:								
75 Percent Poverty	\$ 6,325	\$ 74	\$3,281	\$ 9,680	\$ 416	\$10,096	\$ 6,064	\$4,032
100 Percent Poverty	10,058	132	3,506	13,696	589	14,285	8,520	5,765
130 Percent Poverty	12,995	201	3,735	16,931	728	17,659	10,537	7,122

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



Table 39

**Estimated Impact of Standardizing State Medicaid Benefits Packages Under Two  
Alternative Benefits Package Models for Non-Institutionalized Persons in 1989<sup>a/</sup>**  
(amounts in millions)

	Original State Benefit Package	Cost of Improving to Median State Benefits Package (Washington Model)			Cost of Improving to Nation's Most Comprehensive Medicaid Benefits Package (Minnesota Model)		
		Total Costs	Federal Share	State Share	Total Costs	Federal Share	State Share
Current Law Benefits	\$39.1	\$4.8	\$2.6	\$2.2	\$24.9	\$13.8	\$11.1
Policy Options (Additional Cost) Retain Categorical Criteria:							
75 Percent Poverty	1.9	0.2	0.1	0.1	1.2	0.8	0.4
100 Percent Poverty	3.6	0.4	0.3	0.1	2.3	1.5	0.8
130 Percent Poverty	4.4	0.5	0.3	0.2	2.8	1.7	1.1
Eliminate Categorical Criteria:							
75 Percent Poverty	10.1	1.2	0.7	0.5	6.4	3.8	2.6
100 Percent Poverty	14.3	1.7	1.0	0.7	9.1	5.5	3.6
130 Percent Poverty	17.7	2.1	1.3	0.8	11.2	6.7	4.5
Cover Pregnant Women and Infants Up to 185 Percent of Poverty	1.2	0.1	0.1	--b/	0.7	0.4	0.3

<sup>a/</sup> Excludes persons in institutions.

<sup>b/</sup> Less than \$100 million.

Source: Benefits calculations provided by Kenneth Thorpe of the Harvard School of Public Health.

participate in the program. The second alternative is a "high range" estimate that assumes persons enroll at the same overall rate as under current policy (72 percent). This differs from our "current pattern estimate" based on age, sex, health status, employment, and income in which approximately 63 percent of those eligible enroll.

Under the full enrollment assumption, the cost of raising the eligibility level to 100 percent of poverty and eliminating categorical requirements is 55 percent higher than our "current pattern estimate." Under the assumption that 72 percent enroll, the costs are 14 percent higher than our "current pattern estimate" (Table 40).

Enrollment levels could be improved through outreach programs. This would not only increase the cost of the Medicaid expansions, but would likely result in the enrollment of many currently eligible persons who are not enrolled. This could have a dramatic impact on program costs since an estimated 8.9 million eligible persons are not enrolled. The estimates of program expansion do not include outreach initiatives.

#### d. Regional impacts

Most of those who become covered under these Medicaid expansions are located in the southern region of the United States. If Medicaid income eligibility limits are increased to the poverty level while retaining current categorical criteria, about 73 percent of new enrollees would be persons living in the South, while only about 6.3 percent would be persons living in the Northeast (Table 41). If eligibility were increased to the poverty level together with eliminating categorical requirements, about 53 percent of new enrollees would be located in the South.

The concentration of new enrollees in the South reflects that current Medicaid eligibility levels in southern states are on average lower than in other states and incomes in these states tend to be lower than in other regions of the country. In fact, the South includes about 35 percent of

Table 40

## Medicaid Enrollment and Program Costs Under Alternative Enrollment Assumptions

	Average Monthly Enrollment (in millions)			Annual Program Costs (in billions)		
	Full Enrollment <sup>a/</sup>	Current Pattern Estimate	High Range Enrollment Estimate <sup>c/</sup>	Full Enrollment	Current Pattern Estimate	High Range Enrollment Estimate
Retain Categorical Criteria						
75 percent poverty	4.2	2.7	3.0	\$3.3	\$1.9	\$2.2
100 percent poverty	6.2	4.2	4.5	5.5	3.6	3.9
130 percent poverty	8.5	5.5	6.1	7.3	4.4	5.0
Eliminate Categorical Criteria						
75 percent poverty	15.2	9.3	11.0	\$16.1	\$10.1	\$11.8
100 percent poverty	21.3	13.4	15.4	22.2	14.3	16.3
130 percent poverty	29.5	18.3	21.3	27.8	17.7	20.5

<sup>a/</sup> Assumes all eligible persons enroll.

<sup>b/</sup> Estimates based upon analysis of enrollment patterns in the existing program age, sex, income, health status, employment status, and insured status. This is the estimate used in developing the enrollment estimates discussed above.

<sup>c/</sup> Assumes overall average rate of enrollment among persons newly eligible for the program is the same as in the current program.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 41

## Distribution of Program Costs and Newly Enrolled Persons Under Selected Medicaid Expansions by Census Region

	Total Cost <sup>a/</sup> (in billions)	Percent Distribution of Costs by Census Region			Average Monthly Newly Enrolled Persons (in millions)	Percent Distribution of Newly Enrolled Persons by Census Region			
		North East	North Central	South West		North East	North Central	South West	
Retain categorical criteria:									
75 percent poverty	\$ 1.9	2.9%	3.9%	79.8%	2.7	3.3%	7.9%	74.6%	14.2%
100 percent poverty	3.6	6.3	9.0	73.0	4.2	7.4	7.7	71.0	13.9
130 percent poverty	4.4	7.2	11.6	70.2	5.5	8.8	10.9	67.2	13.1
Eliminate categorical criteria:									
75 percent poverty	\$10.1	10.8%	18.8%	52.7%	9.3	11.2%	17.7%	46.8%	21.8%
100 percent poverty	14.3	11.3	16.4	52.8	13.4	12.2	17.1	48.8	21.9
130 percent poverty	17.7	11.5	16.2	51.9	18.3	12.8	18.3	46.9	22.0

<sup>a/</sup> Includes expenditures for benefits and administration.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



the nation's poor and about 43 percent of the nation's uninsured. Further, the average AFDC income eligibility level for a family of four in southern states is about 35 percent of the poverty level compared with about 56 percent of the poverty level in other states). Consequently, a uniform nationwide income eligibility level for Medicaid would have a disproportionate impact on the South.

These results reflect some of the major issues in setting a nationwide Medicaid income eligibility standard. For example, the financial burden of these expansions will, in part, be concentrated among lower income states which may have difficulty raising the funds required for the program. Moreover, due to differences in the cost of living across states, which are not taken into account in setting the poverty standard, it is unclear that a standardized national income eligibility limit is appropriate.

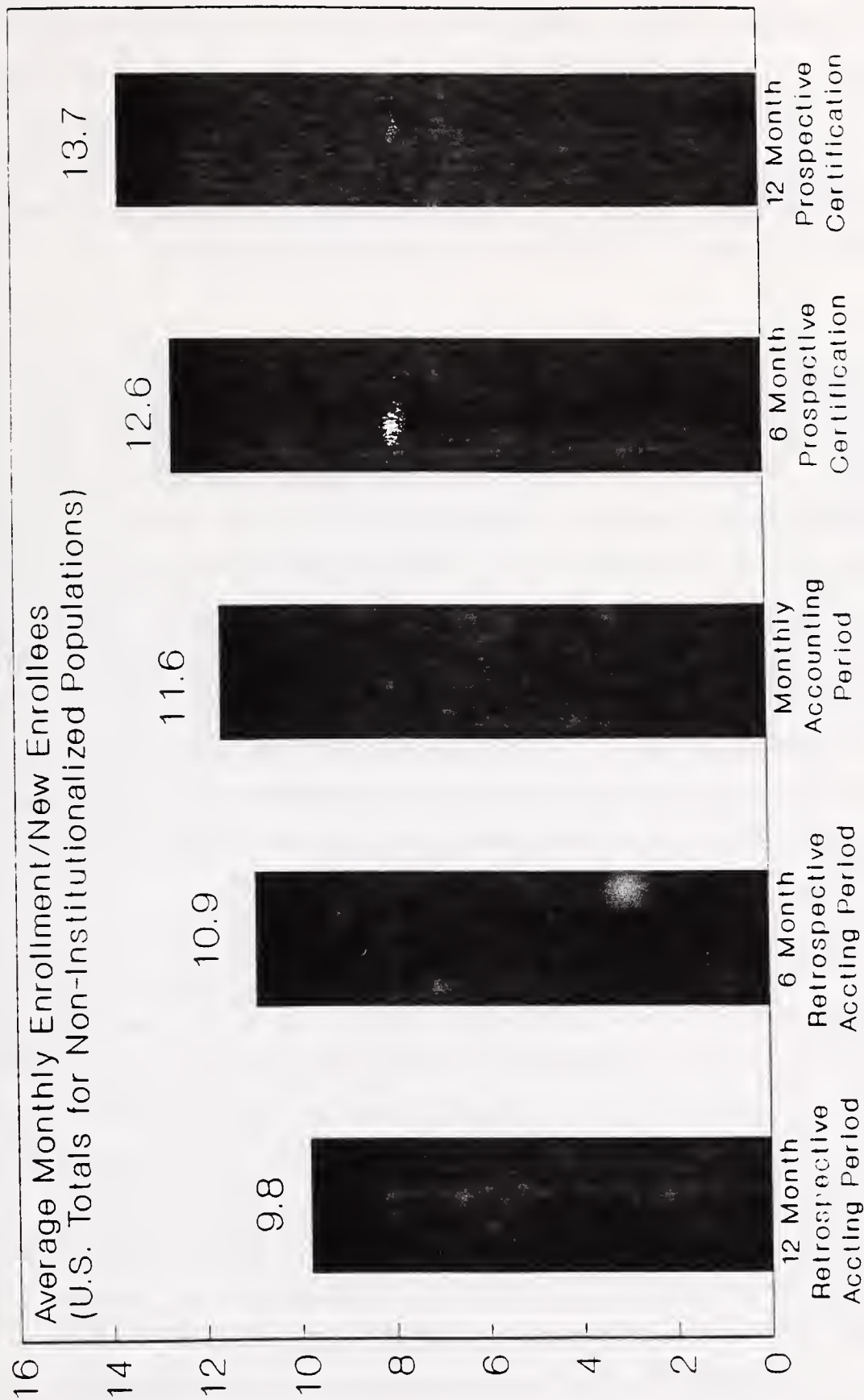
#### e. Eligibility determination

The period over which income is counted (i.e., accounting period) in determining eligibility and the period of recertification for eligibility are key factors influencing the number of persons eligible for the Medicaid expansion options, and how many remain enrolled at any time. In modeling the Medicaid expansion options, we apply a monthly accounting period for determining income eligibility and a six-month recertification period.

Using different assumptions about the accounting period or the recertification period results in substantially different estimates of the number of persons eligible and enrolled in Medicaid and the costs of the program. Figure 15 presents the impact on the number of people enrolled in Medicaid if the eligibility level is increased to 100 percent of poverty but different periods are used for calculating income and recertifying eligibility. In terms of the accounting period, some have suggested basing eligibility on more than one month's income and using a six- or twelve-month retrospective accounting period. This would result in fewer people becoming eligible for Medicaid because individuals who become unemployed and enroll in

FIGURE 15

# Impact of Increasing the Medicaid Eligibility Limit to the Poverty Line under Alternative Accounting Period Methods in 1989



Persons in Millions

a/Assumes Assets Test Is Increased to \$5,000 and Medicaid eligibility is decoupled from Public Assistance eligibility. Excludes medically needy income spend-down enrollees.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM)

Medicaid in the first month they are unemployed may have to wait several months before becoming eligible if their eligibility is based on their prior 6- or 12-month income. The number of persons enrolled using a 6- or 12-month retrospective accounting period is 10.9 million and 9.8 million, respectively. This is below the number we estimate would be enrolled using a monthly accounting period (11.6 million persons). The cost of the program when eligibility is based on a six- or twelve month retrospective accounting period is \$8.8 billion and \$7.7 billion, respectively (Figure 16).

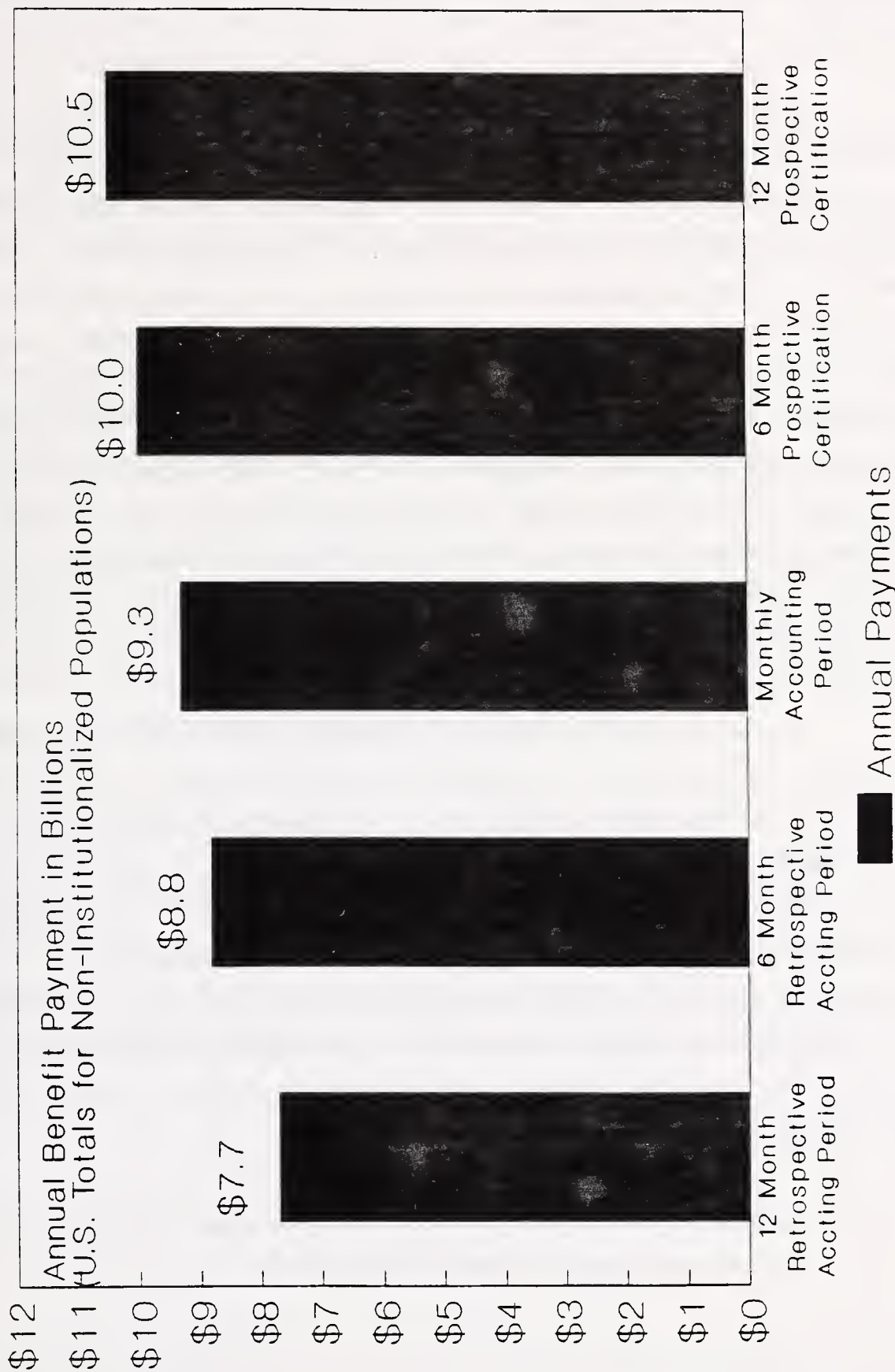
Similarly, it has been suggested that the recertification period be lengthened to reduce the burden on potential enrollees created by requiring monthly recertification for eligibility and to increase continuity of coverage. With a 6- or 12-month certification period, eligibility would be determined using a monthly accounting period, but persons could remain enrolled for a continuous 6 or 12 months before being required to recertify their eligibility. Lengthening the recertification period would result in an increase in average monthly enrollment because some persons may remain enrolled during months their income is above the eligibility level. Average monthly enrollment under 6- and 12-month prospective certification would be 12.6 million and 13.7 million persons, respectively (Figure 15). Program costs would be \$10.0 billion and \$10.5 billion under 6- and 12-month certification, respectively (Figure 16).

The primary reason for the increase in average monthly enrollment is that many persons are eligible for Medicaid for only part of the year. Some persons who enroll in Medicaid are employed for part of the year, often in seasonal or part-time jobs. Monthly certification captures these shifts in and out of employment and persons are enrolled in Medicaid for only those months they are eligible. While this assures that persons do not remain on Medicaid any longer than they are eligible, it also creates a burden on enrollees and may create barriers to enrollment. In contrast, 12-month prospective certification bases eligibility on monthly income, but once a person is enrolled he/she does not need to be recertified for 12 months. Under this approach a seasonal worker who is employed from May through October



FIGURE 16

# Impact of Increasing the Medicaid Eligibility Limit to the Poverty Line under Alternative Accounting Period Methods in 1989



a/Assumes Assets Test is Increased to \$5,000 and Medicaid eligibility is decoupled from Public Assistance eligibility. Excludes medically needy income spend-down enrollees.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM)



and ineligible for Medicaid during those months could enroll in Medicaid in November and remain covered for 12 months including the months he/she is employed.

These changes in eligibility and enrollment resulting from using different accounting periods and periods of eligibility recertification are particularly important as Medicaid eligibility levels increase and the program begins to enroll an increasing number of low-income workers. At eligibility levels at 40 or 50 percent of the poverty level many persons are on Medicaid all year or if they are enrolled for only part of the year, they are uninsured for the remaining months of the year. In contrast, at higher eligibility levels persons such as seasonal and part-time workers who commonly experience fluctuations in income throughout the year would become enrolled. As the discussion above illustrated, whether or not these persons would be eligible for Medicaid for the portion of the year they are unemployed depends to a large extent on which accounting period is chosen and how often enrollees are required to be recertified.

In examining the impact of changes in eligibility certification no behavioral assumptions were made about likely changes in enrollment. For example, while monthly eligibility certification has been criticized for discouraging enrollment, we would expect that enrollment rates would be higher under a six- or twelve-month certification period. Thus, longer certification periods might be expected to increase interest in enrolling. Alternatively, estimating eligibility and enrollment on the basis of an individual month's income may overestimate enrollment, if individuals and families who are eligible but healthy and who anticipate only a brief period of low income choose not to enroll.

##### 5. Medicaid Buy-In for Non-Institutionalized Persons with Incomes Below 185 Percent at the Poverty Threshold

Many uninsured persons earn too much money to qualify for Medicaid but are not offered or cannot afford employment-based insurance. A Medicaid

buy-in program which allows individuals to purchase Medicaid on a sliding scale premium would enable many of these uninsured persons to obtain coverage. Further, many of the uninsured have Medicaid coverage for part of the year and are uninsured for the other part of the year, largely as a result of changes in employment status. A Medicaid buy-in program would enable these persons to remain on Medicaid when they may otherwise be uninsured. A Medicaid buy-in would differ from the medically needy program in that the buy-in would provide first dollar coverage while medically needy programs serve as catastrophic programs.

Some Medicaid buy-in proposals would extend coverage to all uninsured; others limit the program to those within certain income limits or categories. The option modeled in this analysis limits the buy-in to those persons with incomes below 185 percent of poverty. Premiums would be determined on a sliding scale based on income. Persons between the Medicaid eligibility level and 185 percent of poverty would be required to pay 5 percent of their income toward the premium. These persons would also be responsible for a \$100 deductible and 20 percent co-insurance. Persons below 100 percent of poverty would not have any cost-sharing.

The following assumptions are made about enrollment: 1) there will be no change in enrollment among those currently eligible for Medicaid; 2) the newly eligible who are currently uninsured will enroll at the same rate as upper income persons who purchase non-group coverage; and 3) all newly eligible who currently purchase non-group insurance will drop that coverage and purchase the Medicaid buy-in. Exhibit 8 specifies these assumptions in more detail.

## Exhibit 8

### Subsidized Medicaid Buy-In

Target Population:	Low-income uninsured with incomes below 185 percent of poverty.
Eligibility Criteria:	
▪ Categorical eligibility:	No.
▪ Assets:	Asset eligibility limit is raised to \$5,000 nationwide.
▪ Deductions:	Unlike current AFDC eligibility, no deductions would be permitted for work expenses, child care, and other expenses.
▪ Spenddown provisions:	
Duration of Coverage:	Monthly income eligibility determination; six-month recertification.
Benefits:	Mandatory Medicaid benefits with the addition of mental health and prescription drugs.
Financing Issues:	
▪ Cost Sharing:	No premiums or deductible for persons below 100 percent of poverty; between 100 and 185 percent of poverty, 10 percent co-insurance and \$125 deductible for individual and \$250 for a family.
▪ Other:	Available on sliding scale premium; persons between the Medicaid eligibility level and 185 percent of poverty are required to pay 5 percent of their income toward the premium.
Modeling Assumptions:	
▪ Enrollment:	No change in enrollment among those currently eligible for Medicaid.  The newly eligible currently uninsured enroll at the same rate as upper income persons who purchase non-group insurance.  All newly eligible who currently purchase non-group insurance will purchase the Medicaid buy-in.  A small proportion of the employed insured will purchase the Medicaid buy-in if it is less expensive than their current insurance.  All spenddown Medicaid enrollees who become eligible for buy-in will enroll in the buy-in program. <b>Lewin/ICF</b>

#### a. Number of people affected

The buy-in program would have a large impact on the number of uninsured. We estimate one-third of the currently uninsured would enroll in a Medicaid buy-in (Table 42). In addition, the buy-in program would affect persons who are currently insured. Those enrolling would include 2.3 million persons who drop non-group coverage in favor of the buy-in. We would expect this both because the cost of the buy-in is substantially less than typical non-group premiums and the benefits are more comprehensive.

Some buy-in participants would be enrolled only part-year. This is because some may be covered by an employer plan for part of the year. Others may be Medicaid-eligible part-year. They may lose eligibility for Medicaid as their income increases but may be able to retain coverage through the buy-in. This enhances continuity of coverage among populations who move in and out of employment. On an average monthly basis, 2.5 million people would be enrolled in the Medicaid buy-in for only part of the year. Most of these part-year participants would be enrolled in employer-based plans for the other part of the year.

#### b. Program costs

A subsidized Medicaid buy-in is estimated to cost \$20.7 billion (Table 43), \$2.8 billion of which represent enrollee premium payments. This represents a 46 percent increase in the cost to the government of the Medicaid program. Those costs are substantially higher than for the previous options, largely because of the greater number of persons enrolled. However, administrative costs are assumed to be 25 percent greater than the current Medicaid program to reflect the cost of administering coinsurance and premium payments. The other options assume that the relative burden of administrative cost to the program remains unchanged.



Table 42

Estimated Number of Persons Enrolled in Medicaid Buy-In Option  
by Full and Part-Year Enrollment Status<sup>a/</sup>

	<u>Persons Enrolled (in millions)</u>	
	<u>Ever Enrolled in Year</u>	<u>Average Monthly Enrollment</u>
Total	20.7	16.1
Full-Year Participants	13.6	13.6
Uninsured Under Current Law	10.3	10.3
Persons Who Drop Non-Group Coverage to Buy-In	2.3	2.3
Medicaid Income Spend-down Participants Who Transfer to Buy-In <sup>b/</sup>	1.0	1.0
Part-Year Participants	7.1	2.5
Part-Year Medicaid	0.6	0.2
Part-Year Employer Coverage	3.9	1.4
Part-Year Non-Group	2.6	0.9

<sup>a/</sup> Subsidized Medicaid buy-in coverage is available to all persons with incomes below 185 percent of the poverty level.

<sup>b/</sup> Individuals who currently participate under Medicaid income spend-down are assumed to shift to buy-in if their income is low enough to qualify for the program (below 185 percent of poverty). Under this assumption, there are 1.0 million non-institutionalized medically needy who shift into buy-in with about 800,000 remaining covered under spend-down.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 43

Analysis of Program Costs Under Medicaid Buy-In Proposal  
for Non-Institutionalized Persons in 1989<sup>a/</sup>  
(in billions)

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Benefit Payments	\$19.5
Medically Needy Who Shift to Buy-In <sup>b/</sup>	3.0
Other Participants	16.5
Administrative Costs (assumed to equal six percent of benefit payments) <sup>c/</sup>	<u>1.2</u>
Total Program Costs	\$20.7
Less Premium Payments <sup>d/</sup>	<u>(2.8)</u>
Net Program Costs	<u>\$17.9</u>
Federal Share	\$10.0
State Share	7.9

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<sup>a/</sup> Under this option, Medicaid buy-in is available only to persons with incomes below 185 percent of the poverty threshold.

<sup>b/</sup> It is assumed that all non-institutionalized medically needy will shift into buy-in provided their income is low enough to qualify for buy-in. Under this assumption, about \$3,141 million in medically needy benefits costs for non-institutionalized persons are shifted to the buy-in program and about \$2,569 million continue to be covered under the medically needy program.

<sup>c/</sup> Administrative costs as a percentage of benefit payments are assumed to be about 25 percent greater than the current Medicaid program to reflect the cost of administering the program and premium collections.

<sup>d/</sup> Participants are required to make a premium payment equal to three percent of income.

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Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

## 6. Illustrative Medicaid Expansion for Non-Institutionalized Persons

The illustrative Medicaid expansion comprises three of the options analyzed above: 1) the eligibility level is raised to the poverty level with categorical eligibility eliminated; 2) medically needy programs are mandated in all states; and 3) coverage is extended to pregnant women and infants with incomes up to 185 percent of the poverty level. Analyzing an illustrative Medicaid package allows us to examine the interaction among Medicaid options.

### a. Number of people affected

In an average month, 14.7 million persons become covered under the illustrative plan (Table 44). This represents a two-thirds increase in the number of people enrolled in Medicaid. Combining Medicaid options results in over 50 percent fewer pregnant women and infants attributed to that program component than when that option was examined alone. This is because some of the pregnant women and infants become covered when the eligibility level is increased to 100 percent of poverty.<sup>3</sup>

Children experience the largest increase in coverage under this plan, especially children under age 6 (Table 45). This plan would cover over one-third of the currently uninsured children. This may somewhat overestimate the impact on the uninsured because some of these persons would be covered by Medicaid for only part of the year and remain uninsured for the other part of the year.

By design the plan has the largest impact on persons with annual incomes below 100 percent of poverty. However, it covers persons in all income levels even those with annual incomes substantially above 100 percent of poverty. This occurs for three reasons. First, most pregnant women and infants are enrolled with incomes between 100 and 185 percent of poverty.

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<sup>3</sup> Since this analysis provides estimates for 1989, those states that are not yet at 100 percent of poverty for pregnant women and infants are included in this analysis.

Table 44

**Incremental Change in Enrollment and Program Costs Under an Illustrative Medicaid Expansion  
Proposal for Non-Institutionalized Persons in 1989**

Change in Eligibility	Incremental Increase in Enrollment Under Policy (in millions) <sup>a/</sup>			Incremental Increase in Program Costs Under Policy (in billions) <sup>b/</sup>		
	Ever Eligible In Year	Ever Enrolled In Year	Average Monthly Enrollment	Total Cost	Federal Share	State Share
Increase Income Eligibility to Poverty Level (for categorical groups only) <sup>c/</sup>	7.6	5.1	4.2	\$ 3.6	\$ 2.3	\$ 1.3
Increase Income Eligibility to Poverty Level and Eliminate categorical criteria <sup>d/</sup>	17.5	11.5	9.2	10.7	6.2	4.5
Cover All Pregnant Women and Infants Up to 185 Percent of Poverty <sup>e/</sup>	2.2	1.5	1.3	0.7	0.4	0.3
Total New Enrollees	27.3	18.1	14.7	\$15.0	\$ 8.9	\$ 6.1

<sup>a/</sup> Eligibility is assumed to be certified for a period of six months (pregnant women through 60 days postpartum), the asset eligibility limit is increased to \$5,000 (no assets test for pregnant women), and medically needy programs are implemented in all states.

<sup>b/</sup> Estimates include benefits payments and administrative costs. It is assumed that states maintain their existing benefit packages.

<sup>c/</sup> For those categorical eligibility groups criteria, the Medicaid income eligibility limit would be set at 100 percent of the poverty level in all states.

<sup>d/</sup> In this provision, eligibility is decoupled from the current categorical eligibility criteria and the income eligibility limit is increased to the poverty level.

<sup>e/</sup> In all policy options, eligibility is certified for a period of six months, the asset eligibility limit is increased to \$5,000, and medically needy programs are implemented in all states.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



Table 45

Distribution of New Enrollees and Program Costs by Demographic Group Under an Illustrative Medicaid Expansion<sup>a/</sup>

	Average Monthly Enrollment (in thousands)	Total Program Costs <sup>b/</sup> (in millions)	Average Program Costs Per Enrollee
Total Newly Eligible	14,759	\$14,738 <sup>c/</sup>	\$ 999
Income Spenddown	767	3,506	4,571
Income Eligible Population	13,992	11,232	803
Dependent Children			
Under Age 6	1,913	502	262
Age 6-14	1,563	417	267
Age 15-18	558	513	919
Adults			
Under Age 25	2,247	1,617	719
Age 25-34	2,759	2,773	1,005
Age 35-64	3,433	4,303	1,253
Age 65+	1,519	1,107	729
Sex			
Males	6,339	4,326	682
Females - Nonpregnant	6,795	5,987	881
Females - Pregnant	858	919	1,071
Self-Reported Health Status			
Poor/Fair	2,967	4,665	1,578
Good/Excellent	11,025	6,567	595
Annual Family Income as a Percent of Poverty			
Less than 75 Percent	5,979	4,732	791
75 - 99 Percent	3,919	3,332	850
100 - 124 Percent	1,045	1,099	1,052
125 - 149 Percent	723	721	997
150 Percent or more	2,326	1,225	527
Census Region			
North East	1,657	1,213	732
North Central	2,663	2,013	756
South	6,683	5,844	875
West	2,989	2,162	723

<sup>a/</sup> Under this illustrative policy option, eligibility is decoupled from public assistance eligibility, the income limit is raised to the poverty level, the assets test is raised to \$5,000, medically needy programs are established in all states, and coverage is extended to pregnant women and infants with incomes up to 185 percent of the poverty level.

<sup>b/</sup> Includes benefit payments and administrative costs.

<sup>c/</sup> This Medicaid expansion policy would also result in more rapid spend-down for persons qualifying as medically needy under current policy resulting in an additional \$132 million in Medicaid program costs bringing the total cost of this policy to about \$15.0 billion.

Second, we are comparing annual incomes to average monthly enrollment in Medicaid. A family's income level and insurance status may change during the course of a year. For example, a family's annual income may be \$14,000 for 6 months of the year (\$28,000 annualized rate) and zero for 6 months due to unemployment. During the period of unemployment the family may obtain Medicaid coverage under this plan. This family would appear to be eligible for Medicaid with a \$14,000 income (119 percent of poverty for a family of four). Third, the 6-month certification period for enrollment may enable persons to remain on Medicaid during months they are ineligible. Using the same example above, once the family wage earner becomes unemployed, he/she would enroll in Medicaid and remain covered for 6 months. After 6 months, he/she would need to be recertified. If, after two months of being unemployed the wage earner regained employment, he/she would still remain enrolled in Medicaid for an additional four months with a monthly income above the eligibility level. (Note that if the individual received employment-based insurance, this would become the primary insurance and Medicaid would become secondary.)

Enrollment in Medicaid through spenddown is 1-1/2 times higher under the illustrative Medicaid plan (Table 46). This occurs largely as a result of eliminating categorical requirements. The additional 300,000 categorically eligible spenddown persons are from those states that need to establish a medically needy program.

While 14.7 million newly eligible persons would become covered in an average month, an additional 18.1 million persons would become covered some time during the year. Of these 18.1 million new participants, 40 percent would be persons who are uninsured all year (Table 47). Thus, the number of persons without health insurance throughout the year (31.8 million) would be reduced by about 23 percent under this policy.

About 60 percent (10.8 million) of those who would become covered under the illustrative Medicaid expansion some time during the year would be persons who were insured through some other source for at least some portion

Table 46

**Impact of Illustrative Medicaid Expansion on the Non-Institutionalized Medicaid Income Spend-down Population (Assumes Medically Needy Programs Are Implemented in All States)**

	Persons (in millions)	Benefits and Administration (in billions)	Average Program Cost Per Person
Current Income Spend-down	1.8	\$ 5.8	\$3,141
Income Spenddown Under Expansion			
Total	2.6	9.7	3,812
Persons Currently Enrolled	1.8	5.9	3,301
All Newly Enrolled Persons	0.8	3.5	4,571
Newly Enrolled Persons in Categorical Groups	0.3	0.7	2,614
Newly Enrolled Persons in Non-Categorical Groups	0.5	2.8	5,512

<sup>a/</sup> Under this illustrative policy option, eligibility is decoupled from public assistance eligibility, the income limit is raised to the poverty level, the assets test is raised to \$5,000, medically needy programs are established in all states, and coverage is extended to pregnant women and infants with incomes up to 185 percent of the poverty level with no assets test. Eligibility is assumed to be certified for six months except for pregnant women where eligibility is certified for 11 months.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 47

Persons Covered Under Illustrative Medicaid Expansion Some Time During  
During the Year by Source of Coverage Under Current Policy

Source of Insurance Under Current Policy	Persons Covered Some Time During Year (in millions)
Uninsured All Year	7.3
Insured Some Time During Year	10.8
Medicare	1.9
Employer Coverage Some Time in Year	5.7
Non-group Coverage	2.3
CHAMPUS/Other Government	<u>0.9</u>
Total	18.1

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



of the year. About 1.9 million of those who would become covered under the expansion are persons covered by Medicare. In addition, about 2.3 million of those who participate in the Medicaid expansion would be persons who terminate their non-group policies (Table 47).

About 5.7 million of those who would participate in the Medicaid expansion would also be covered under an employer health plan some time during the year. Many of these persons are low-wage workers who would be eligible for Medicaid throughout the year despite their employer coverage status (our cost estimates reflect that Medicaid would be secondary payor to the employer coverage). However, many of these persons would be higher-wage workers who become eligible only during months when they are out of the labor force or unemployed.

#### b. Costs of the program

The illustrative Medicaid proposal would increase the costs of the program by \$15 billion, over two-thirds of which is attributed to eliminating categorical eligibility (Table 44). The distributional analysis of program costs shows the high costs per enrollee for spenddown enrollees and pregnant women, and the low cost per enrollee for children (Table 45). The costs for spenddown eligibles would increase by two-thirds from \$5.8 to \$9.7 billion (Table 46).

### B. MEDICARE ELIGIBILITY EXPANSION AND REFORM

Medicaid provides health insurance coverage for low income disabled who qualify for Supplemental Security Income (SSI). For those who are permanently and totally disabled, who have worked or are adult dependent children of workers, income support can be available through Social Security Disability Insurance (SSDI) and health insurance can be available through Medicare. However, Medicare coverage has many important gaps for the chronically ill and disabled. It does not cover outpatient prescription drugs and has limits on hospital and physician care. Despite these limits, Medicare

coverage is viewed as an alternative primary insurance by many advocates of the disabled. The Medicare Catastrophic Coverage Act would have closed a number of these gaps, but Congress repealed the Medicare provisions of the Act in OBRA 1989.

A major limitation of Medicare coverage is that the disabled under age 65 receiving cash assistance under SSDI do not become eligible for Medicare until two years after their initial receipt of cash benefits. This waiting period has been cited as a major barrier to access to health care for those disabled with incomes above the SSI-eligibility level (which assures Medicaid coverage) and who do not have access or cannot afford continuation coverage or nongroup health insurance. About 27 percent of SSDI recipients have no insurance during months 18-24 of the waiting period. The waiting period is a particular problem for persons with AIDS, cancer, and other rapidly debilitating conditions who may not survive the two-year period. One proposal that has been put forward is to eliminate the two-year waiting period. This section presents estimates of the impact of this proposal. They are based on an analysis conducted by Bye and Riley in the Social Security Bulletin.<sup>4</sup>

#### 1. Number of People Affected

The number of people affected is the number of disabled workers who become entitled to SSDI cash benefits. This is estimated to about 3 million people.

#### 2. Costs of the Program

Based on a 1972 cohort of disabled-worker beneficiaries, Bye and Riley estimated the additional average cost per beneficiaries under age 62 of eliminating the waiting period to be approximately \$2,692 (in 1981 dollars).

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<sup>4</sup> Bye, Barry V., and Riley, Gerald F. "Eliminating the Medicare Waiting Period for Social Security Disabled Worker Beneficiaries." Social Security Bulletin. 52(May 1989):2-15.

This estimate assumes that Medicare is the primary payor. The additional cost represents a 45 percent increase over the average cost per beneficiary estimated for an 8-year period.

Thirty percent of the total cost associated with eliminating the waiting period was attributed to persons who died within the first 2 years of SSDI eligibility (about 12.8 percent of the new beneficiaries). The high proportion of costs associated with this group is a function of the high health care utilization and medical care costs associated with their disabilities.

Bye and Riley note that since their analysis is restricted to a cohort of disabled persons under age 62 at the time of entitlement, their cost estimates understate some costs associated with eliminating the waiting period. Including disabled persons age 62-64 would result in higher costs. Furthermore, current cohorts of disabled beneficiaries are likely to include a number of persons with AIDS who have substantially higher medical care costs than those beneficiaries in the 1972 cohort study that was the basis of their estimates.

#### C. REQUIREMENTS FOR EMPLOYER-BASED INSURANCE

Because approximately three-fourths of the uninsured are employed or dependents of employed persons, proposals to improve the availability of employer-based insurance have been the focus of much recent attention. In fact, most of the options currently being debated include some form of employer mandate for providing insurance. Two states have already enacted some form of employer mandate: Hawaii requires employers to provide insurance for employees working more than 19 hours per week. In April 1987, Massachusetts became the first state to require employers to provide insurance or pay a tax penalty. Other states are considering enacting similar requirements, and the Congress is also debating employer mandates.



Employer mandates can take three forms.

- **Mandate ("Thou Shalt")** requiring employers to provide insurance meeting certain requirements to their employees and their dependents.
- **"Play or pay"** approach in which employers must provide insurance to their employees and their dependents or pay a tax that approximates the cost of providing insurance. This approach is intended to change behavior by encouraging employers to provide insurance, but permits them to pay a tax in lieu of insurance.
- **"Contributory tax"** whereby employers who do not offer coverage must pay a tax to help finance initiatives for the uninsured. Set below the cost of providing insurance, this tax is not intended to encourage employers to offer coverage although some will choose to provide coverage instead of paying the tax. This approach can generate financing for other health insurance initiatives from non-insuring employers while shielding them from the full cost of providing insurance to their employees.

In designing an employer mandate, decisions must be made about specific components of the plan. These details can have a significant impact on the numbers insured, costs to employers, and the distribution of financing among individuals, employers and government. The components that can be varied include:

- **Who is to be Covered.** The extent of coverage provided under a mandate depends on who is eligible. Mandates may apply to employees only or to both employees and their dependents. Mandates can cover only full-time workers or also include some part-time workers. Whether part-time employees and dependents are included under the mandate affects the extent to which employers who currently provide insurance are affected.
- **Premium Share.** In most employer plans, employers and employees share the cost of insurance. The relative premium contributions vary across employers and by type of coverage (i.e., individual or family), ranging from zero employer contribution to employer payment of the full premium. The employer contribution for dependent coverage tends to be a smaller proportion of the total premium than that for employee coverage only. The level at which the premium share is established has an impact on both employers and employees, and presents a tradeoff between a goal of minimizing the cost to employers and maximizing coverage. If the employer contribution is established at a level greater than current practice, a large number of firms that currently provide insurance



will be affected and required to upgrade their level of contribution. Setting the premium share at a lower level for employers requires fewer firms to change their level of participation but increases the expense to the employee. This may affect employees' ability to afford participation in a plan and the impact of the mandate on the uninsured.

- **Benefits.** Insurance plans vary widely in the extent of coverage offered in their benefits packages and in the provision of services to persons with pre-existing conditions. In considering a national mandate of employer-based insurance, comprehensiveness of benefits is an important issue. A more comprehensive benefits package is more expensive. A less complete plan, while less costly, may have the disadvantage of not covering needed services, thereby leaving persons underinsured. Furthermore, persons with certain health problems, or pre-existing conditions, are often limited by insurance plans as to what benefits they may utilize if they are not excluded from coverage altogether. The major decisions regarding benefits are whether to establish a catastrophic benefit package or a more comprehensive package, and whether to restrict benefits and participation for persons with pre-existing conditions.
- **Cost-sharing.** Most employer plans require some employee cost sharing in the form of deductibles and coinsurance. The challenge in setting these cost sharing limits is to prevent unnecessary utilization while not creating barriers for persons who need to obtain health care. The employer plans analyzed employ different cost sharing requirements.

We analyzed two employer mandate options -- a "thou shalt" mandate and a "play or pay" approach. Within these options, a number of variations were also analyzed. A brief description of these options and the results of the analysis are provided below.

#### 1. Employer Mandate ("Thou Shalt")

The "Health Benefits for All Americans Act" introduced by Senators Edward Kennedy and Henry Waxman was used as the framework for our analysis of an employer mandate. This is the most recent national bill aimed at extending health insurance to all employed persons and their dependents. This bill includes an employer mandate with a specified benefit package, Medicaid eligibility expansion to 100 percent of poverty without regard to categorical

eligibility, and a Medicaid buy-in. We analyzed three employer mandate variations:

- Employer mandate with the specified benefit package.
- Employer mandate with a catastrophic benefit package.
- Employer mandate coupled with Medicaid eligibility expansion and Medicaid buy-in.

A description of the options and the results of the analysis are presented below.

**a. Employer mandate with specified benefit package**

Employers would be required to provide health insurance to all employees who work at least 17.5 hours per week and to their dependents. No firms would be exempt from the mandate, although small firms with fewer than 10 employees that have been in business for less than two years would be required to offer a low-cost catastrophic plan in lieu of the specified package of basic services. Employers with five or fewer employees would be phased into compliance over five years.

The basic benefit package for an employer mandate is specified in Exhibit 9. Specifying a basic benefit package is not meant to preclude employers from offering more comprehensive health insurance plans but rather is established as a benefits floor. Employers currently offering less comprehensive benefits would be expected to upgrade those plans. The plan also prevents employees from being excluded from coverage based on their health status or any pre-existing condition.

In an effort to improve the accessibility of insurance to lower income employees through this plan, premium cost is shared between employer and employee on the basis of employee income. Employers are required to pay 80 percent of the cost of the premium for both employees and their dependents

## Exhibit 9

### Employer Mandate with Specified Benefits

- **PERSONS COVERED:** Employers are required to provide health insurance to employees who work at least 17.5 hours per week and to their dependents.
- **EMPLOYER AFFECTED:** All firms are affected:
  - Firms that employ fewer than 10 employees and have been in business for less than two years are required to offer a low cost catastrophic plan.
  - Employers with five or fewer employees will be phased-in over five years.
- **BENEFITS:**
  - Basic Package
    - Inpatient and outpatient hospital coverage
    - Inpatient and outpatient physician services
    - Diagnostic tests
    - Laboratory and x-ray services
    - Prenatal care
    - Well-baby care
    - Inpatient mental health care for 45 days
    - Outpatient psychotherapy for 20 visits
  - Catastrophic limit of \$3,000 per family
  - Employees may not be excluded from coverage based on their health status or any pre-existing condition.
- **PREMIUMS AND COST SHARING:**
  - Employers must pay 80 percent of the cost of the premium for employees and their dependents with two exceptions:
    - Employers pay the full premium for workers earning less than 125 percent of the minimum wage.
    - Employers are allowed to pay less than 80 percent of the premium for employees who work between 17.5 and 25 hours per week. (We assume employers will pay 50 percent of the premium.)

**Exhibit 9**  
(continued)

- Employees are required to pay a maximum deductible of \$250 for individual coverage and \$500 for family coverage.
- No cost sharing for prenatal and well-baby care.
- Co-insurance may not exceed 20 percent.

■ **EMPLOYER SUBSIDY:** Employers with fewer than 25 employees, whose costs for providing insurance exceeds 5 percent of gross revenues will be eligible for a subsidy of up to 75 percent of the excess amount.

- **PARTICIPATION:**
- Participation is mandatory for employees who work more than 25 hours per week and their dependents.
  - Employees who work between 17.5 and 25 hours per week may decline coverage. (We assume they decline coverage if it is more than 5 percent of their income unless they are currently purchasing non-group coverage at a higher premium. Then individuals will accept employer coverage and drop non-group coverage.)
  - Spousal waiver allowed.



who earn more than 125 percent of the minimum wage; employers must pay the full premium for employees earning less than 125 percent of the minimum wage.

Participation under this plan is mandatory for employees who work more than 25 hours per week and their dependents. Employees working between 17.5 and 25 hours per week may decline coverage. This analysis assumes that workers will decline coverage if the premium cost is more than 5 percent of their income unless they are currently purchasing non-group coverage at a higher premium. In the latter case, we expect that individuals would drop non-group coverage and participate through their employers.

**Number of people affected.** Under this employer mandate, the number of workers with employer-based insurance would increase by 42 percent and the number of dependents would increase by 27 percent. Because coverage is mandatory for most workers and their dependents, this plan would cover 82 percent of the currently uninsured.

The employer mandate would affect the coverage of the uninsured in firms that currently do provide health insurance. Because the plan requires employers to contribute 80 percent toward the premium for most employees and their dependents, many employees who did not purchase coverage for their dependents would elect to obtain family coverage. An additional 2.4 million dependents would become covered in firms that provide insurance. Similarly, about 65 percent of uninsured part-time workers are employed by firms that offer coverage to their full-time workers. Since this plan applies to employees who work more than 17.5 hours per week, an additional 6.4 million part-time workers and their dependents would become insured (Table 48).

A major impact of employer mandates is that they affect the health coverage of many more people than the uninsured. The employer mandate would affect the health coverage of 75.6 million Americans (Table 49). As a result of an employer mandate alone, 25.9 million previously uninsured would obtain coverage. In addition, 23.8 million previously insured persons would switch to employer-based insurance as a result of the mandate. Another 25.9

Table 48

Impact of An Employer Mandate on the  
Number of Persons Covered by Employer Health Plans  
(in millions)

	Workers	Dependents	Total
Persons currently with employer coverage	69.9	74.2	144.1
Dependents who become covered under existing plans <sup>a/</sup>	--	2.4	2.4
Persons who become covered under mandate	29.6	17.7	47.3
Part-time workers excluded under employer plans <sup>b/</sup>	4.8	1.6	6.4
Workers in firms that do not currently sponsor health benefits for any employee	24.8	16.1	40.9
Total workers and dependents with employer coverage under employer mandate	99.5	94.3	193.8

<sup>a/</sup> Although nearly all employer plans offer family coverage many require the employee to pay the full amount of the family coverage premium. Consequently some workers decline the family coverage. Because the mandate requires employers to pay up to 80 percent of the premium, we assume that all employees will elect the family coverage option if they have uninsured dependents.

<sup>b/</sup> It is estimated that about 65 percent of all part-time workers who do not have coverage on their own job are employed by a firm which offers health benefits to full-time workers. (Based on a Lewin/ICF survey of employer health plans for the Small Business Administration (SBA).)

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 49

Persons Affected by the Employer Mandate  
by Source of Health Insurance Coverage Under Current Law

	Persons Covered Under Employer Mandate (in millions) <sup>a/</sup>
Total Affected Under Mandate	75.6
Workers and Dependents in Firms Required to Improve Benefit Package <sup>b/</sup>	25.9
Total Covered Under Mandate	49.7
Uninsured Under Current Policy	25.9
Insured Under Current Policy	23.8
Covered Under Medicaid Under Current Law	5.3
Non-Group Coverage Under Current Law	17.2
Dependent Children Who Become Covered On Own Job	0.1
Covered Under Medicare	3.1
CHAMPUS or Other Government	1.1

<sup>a/</sup> The numbers in this table do not sum to the total because individuals may have had more than one source of coverage under current policy.

<sup>b/</sup> Includes workers and dependents in firms where the employer plan must be modified to the minimum benefit and premium sharing provisions of the plan.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

million workers who have employer-based coverage would have their coverage upgraded to meet the specified benefit and premium sharing provisions of the plan.

The large impact on the currently insured occurs for two major reasons. First, many people who purchase non-group insurance coverage would drop this coverage if they are offered employer-based coverage. As described in Part One of this report, non-group insurance plays a significant role in providing coverage to those without employer-based insurance. Under the employer mandate, approximately 94 percent of persons who currently purchase non-group insurance coverage would now obtain coverage from an employer. Second, 5.3 million higher-wage Medicaid enrollees would become eligible for employer-based insurance and disenroll or receive secondary coverage from Medicaid. Other insured persons would also switch to employer-based insurance, but to a much lesser extent. These are: 100,000 dependents who would become covered on their own job; 3.1 million persons for whom Medicare would become secondary coverage; and 1.1 million persons who would switch from CHAMPUS to employer-based insurance.

Costs of the plan. One of the most surprising impacts of employer mandates is that while they are targeted toward employers that do not provide insurance, firms that currently do provide insurance would also be faced with significant increases in costs. Those firms that fall short of the benefit requirements or the employer premium contribution required by the plan would be required to expand their plans. In addition, firms would be required to insure part-time employees working more than 17.5 hours per week. The cost of plans provided by employers currently offering insurance would increase by \$7.3 billion. Employer costs would increase by \$12.7 billion, while net employee costs would decrease by \$5.4 billion (Table 50). The cost of upgrading benefits and increasing employer premium contributions represents 67 percent (\$8.5 billion) of the increase in costs to these employers. The decline in employee costs is attributable to a lower employee premium share, especially for dependent coverage. Firms that do not now provide insurance would bear the highest cost with an increase in plan costs of \$25.6 billion.



Table 50

Change in Employer Health Plan Costs  
Under Employer Mandate  
(in billions) <sup>a/</sup>

	Firms That Now Offer Insurance To Some or All Workers			Firms That Do Not Now Offer Insurance to Any of Their Workers		
	Employer Plan Costs	Employer Share	Employee Share	Employer Plan Costs	Employer Share	Employee Share
<u>Employer Plan Health Expenditures Under Current Policy</u>	\$143.0	\$114.0	\$29.0	--	--	--
<u>Change in Plan Costs by Employer Mandate</u>						
Coverage of Dependents Excluded Under Current Policy <sup>b/</sup>	0.9	0.8	0.1	--	--	--
Impact of Minimum Benefit and Premium Standards						
Plan Premium Improvements <sup>c/</sup> Improvement in Plan Provisions <sup>d/</sup>	-- 2.0	6.5 2.0	(6.5) --	-- --	-- --	-- --
Cost of Insuring Workers and Dependents Working 17.5 Hours or More	4.4	3.4	1.0	25.6	21.3	4.3
<u>TOTAL PLAN COSTS</u>	150.33	126.7	23.6	25.6	21.3	4.3
<u>CHANGE IN EMPLOYER PLAN COSTS</u>	7.3	12.7	(5.4)	25.6	21.3	4.3

<sup>a/</sup> Includes benefit costs and administration.

<sup>b/</sup> Covered workers who do not elect the family coverage option under existing plans are assumed to elect family coverage under the employer mandate.

<sup>c/</sup> Employers are required to pay a minimum of 80 percent of the premium for all workers.

<sup>d/</sup> Plans that fall short of the minimum benefit provisions of the employer mandate are required to improve the benefits package to the minimum standard.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

**Lewin/ICF**

Of this, employers would pay \$21.3 billion and employees pay \$4.3 billion. In total, employer costs would increase by \$34 billion.

The numbers presented above represent the gross costs to employers. However, the increase in employer costs would be less than this because employers can deduct the cost of health insurance from their federal and state income taxes<sup>5</sup> and employers who currently provide insurance would benefit from a reduction in the cost shift as the newly insured generate less bad debt and charity care. Taking these factors into account, the net new costs to firms that currently provide insurance would be reduced from \$12.7 billion to \$7.8 billion, while the cost to firms that do not now provide insurance would be reduced from \$21.3 billion to \$16.4 billion (Table 51). This may slightly underestimate the net employer costs because tax savings do not apply to those employers who do not pay corporate income tax. However, this underestimate is offset to some extent by the unestimated tax savings from state income tax.

**Industry and firm size.** The employer mandate would have the greatest impact on the service and trade industries. Of the 29.6 million workers who would become covered under the employer mandate, about 57 percent (17.0 million) would be persons employed in either the service or the whole-sale and retail trade industries (Table 52). The impact on these firms is particularly important, given that the growth in employment during this decade has occurred largely in these industries.

The concentration of affected workers among the service and trade industries reflects that these are lower wage industries where the percentage of employers sponsoring coverage is typically low. For example, the 1988 CPS data shows that while about 63 percent of all workers have employer coverage on their job, only about 55 percent of workers in the service industry and about 48 percent of workers in the wholesale and retail trade industries have employer coverage on their own job.

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<sup>5</sup> We estimated the savings from federal income tax deductions for health insurance costs but not from state income tax deductions.

Table 51  
 Net Costs to Employers Under the Mandate  
 (Minimum Benefit Package)  
 (in billions)

	Firms Now Offering Plans	Firms Required To Offer Coverage	All Firms
Gross Increase in Employer Costs	12.7	21.3	34.0
Offsets to Gross Employer Cost Increase			
Premium Reduction for Reduced Charity Care Overhead Charges by Providers	(2.6)	--	(2.6)
Federal Tax Expenditure For Health Benefits Deduction	<u>(2.3)</u>	<u>(4.9)</u>	<u>(7.2)</u>
NET INCREASE IN EMPLOYER COSTS	7.8	16.4	24.2

a/ Charity Care savings by providers are assumed to be passed on to the purchasers of insurance in the form of reduced premiums. Total charity care savings are estimated to be \$2.6 billion under a minimum benefit package.

b/ Assumes an average marginal corporate tax rate of 23 percent.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

The employer mandate would have a large impact on small firms. About 39 percent (11.5 million) of workers who become covered under an employer plan would be from firms with fewer than 25 employees (Table 52). The concentration of newly covered workers among small firms reflects that under current policy, only about 33 percent of persons employed in firms of 25 or fewer employees have employer coverage on their own job. (Other employees of these firms may have coverage through spouses, non-group coverage, Medicaid, or other sources.)

The employer mandate would also have a significant impact on some larger firms. For example, about one-third of those who obtain coverage under the mandate would be in firms of 500 or more employees (Table 52). Of these, about one-fourth would be part-time workers (i.e., persons working 18 to 34 hours per week).

#### b. Variations in mandate design

The impact of employer mandates on coverage and employer costs are sensitive to plan design. As described in the introduction to employer mandates, plans may be varied along four policy dimensions: 1) categories of persons to be covered; 2) premium share; 3) benefits; and 4) cost sharing. Employer costs and the number of people covered can be changed significantly by modifying the plan design along any of these dimensions.

To illustrate the sensitivity of the employer mandate to variations in program design, we analyze eight alternative specifications of an employer mandate. These design variations organized along the policy dimensions above are:

- Who is to be covered.
  - Exempt firms with 10 or fewer employees from mandate.
  - Apply mandate to only full-time workers (i.e., 35 or more hours per week).



Table 52

**Monthly Premiums and Employer Costs per Hour for Workers  
Who Become Covered Under the Employer Mandate**

<u>Firm Size</u>	<u>Newly Insured Workers (in millions)</u>	<u>Employer Costs (in billions)</u>	<u>Average Monthly Premium</u>	<u>Average Employer Cost Per Hour</u>
1-24	11.5	\$11.9	\$110.63	\$0.58
25-99	4.0	4.3	88.15	0.47
100-499	3.9	5.0	87.60	0.45
500+	10.2	12.2	104.91	0.54
<u>Industry</u>				
Construction	2.8	2.7	87.67	0.45
Manufacturing	3.0	4.5	105.69	0.53
Wholesale and Retail Trade	7.4	6.8	96.55	0.51
Services	9.6	10.3	98.74	0.53
Finance, Insurance, Real Estate	1.5	1.5	104.61	0.50
Other	5.3	7.3	117.05	0.60
<u>All Workers</u>	29.6	\$33.1	\$102.86	\$0.54

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

- Exempt temporary workers by applying a four-month waiting period for new employees.
- Exclude benefits of workers from mandate.
- Prohibit spousal waivers (i.e., require workers to take coverage on their own job).
- Premium share.
  - Reduce premium sharing requirements for dependents to 50 percent; maintain premium share for employees at 80 percent.
- Cost sharing.
  - Increase worker cost sharing requirement. We have done this by requiring 50 percent cost sharing for the first \$2,500 in hospitals costs. While providing first dollar coverage for hospital care, this shifts coverage toward a catastrophic plan for hospital care.
- Use "pay or play" tax penalty rather than "thou shalt" mandate.

The impact of these variations are discussed below:

- Exempting firms with 10 or fewer employees from the mandate would reduce the number of persons covered by 14.5 percent, from 49.7 million persons to 42.5 million workers (Table 53). Total employer costs (before taxes) are reduced by 17.6 percent, from \$34.0 billion to \$28.0 billion.
- Requiring employers to cover only full-time workers (those working 35 hours or more per week) would reduce the number of persons covered by about 17 percent to 41.3 million persons. Total employer costs would be reduced by 14.1 percent to \$29.2 billion (Table 53).
- Applying a four-month waiting period for new employees to obtain coverage would reduce coverage for temporary and seasonal workers. These persons move in and out of employment and their high turnover increases the administrative costs of insurance for these workers. This waiting period would reduce the number of persons covered by 4 percent and reduce employer costs by 8.5 percent.
- Requiring only worker coverage (i.e., no coverage for dependents) would reduce the number of people covered by 40 percent and reduce employer costs by 37.4 percent.

Table 53

Net Costs to Employers Under the Employer Mandate with  
Catastrophic Coverage  
(in billions)

	Firms Now Offering Plans	Firms Required to Offer Coverage	All Firms
Gross Increase in Employer Costs	-- <sup>a/</sup>	\$10.5	\$10.5
Offsets to Gross Employer Cost Increase			
▪ Premium Reduction for Reduced Charity Care Overhead Charges by Providers <sup>b/</sup>	(1.3)	--	(1.3)
▪ Federal Tax Expenditures for Health Benefits Deduction <sup>c/</sup>	0.3	(2.4)	(2.1)
Net Increase in Employer Costs	(1.0)	8.1	7.1

<sup>a/</sup> The Catastrophic Plan would have no direct impact of firms that now offer insurance.

<sup>b/</sup> Charity Care savings by providers are assumed to be passed on to purchasers of insurance in the form of reduced premiums. Total charity care savings are estimated to be \$1.5 billion under the Catastrophic Plan.

<sup>c/</sup> Assumes an average marginal corporate tax rate of 23 percent.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

- **Prohibiting spousal waiver** and requiring employees to accept coverage on their own employer's plan rather than as a dependent or spouse on another employer's plan would shift the costs of the plan among employers. It would tend to shift coverage for working dependent spouses away from firms that now offer insurance to firms that currently do not offer coverage.<sup>6</sup> The cost to employers who do not offer insurance would increase by two-thirds or \$14.6 billion. The savings to firms that currently offer insurance would more than offset the cost of complying with other provisions of the mandate.
- **Reducing the employer premium share for dependents** to 50 percent from 80 percent would reduce employers' costs by 17.0 percent (\$5.8 billion).
- **Raising the coinsurance for hospital services** to 50 percent for the first \$2,500 compared to 20 percent coinsurance on hospital care would reduce employer costs 39 percent or \$13.2 billion.
- **Implementing the mandate as a "pay or play" tax incentive program** would reduce the number of people covered and employer costs. Under this plan, all employers who fail to provide a specified level of health insurance to workers would pay a payroll tax on earnings for uninsured workers. If we assume that employers respond by doing whatever minimizes costs, employers with low wage workers would tend to pay the tax rather than purchase insurance while employers of higher wage workers would tend to purchase insurance.<sup>7</sup> Under this option, about 27.4 million workers and dependents would become covered on an employer plan, which is about 45 percent fewer than under the "thou shalt" mandate (Table 53). Total employer costs under this option would be about \$29.7 billion (\$4.3 billion less than under the mandate) of which about \$8.7 billion would be tax payments by employers who do not offer insurance. "Pay or play" approaches are examined more closely in Section 2.

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<sup>6</sup> In some instances, spouses would be shifted from one insuring firm to another firm which currently provides insurance. Our estimates reflect this shift among firms that currently provide insurance.

<sup>7</sup> In analyzing this option, we assumed that employers purchase the insurance only if it is less costly than paying the tax. Because the tax is computed as a percentage of payroll, employers of lower wage workers will generally find it to their advantage to pay the tax while employers of higher wage workers will be more inclined to purchase insurance. We have set the tax rate so that on average the tax payment would be equal to the average cost to the employer of providing insurance. The tax rate used was 5.4 percent on salary and wages up to the Social Security covered earnings amount (\$48,000 in 1989). The methodology used to model employer responses to tax incentive plans is discussed in Appendix A of this report.



c. Employer mandate with catastrophic benefit package

The major reason employers claim for not offering health insurance is that it too expensive. For many employers, the cost of insurance plans requiring specified benefits is prohibitive. In view of this, it has been suggested that a less costly alternative for employers is an insurance plan composed only of catastrophic benefits. The maximum deductible under this arrangement would be substantially higher than under the mandate with specified benefits (Exhibit 10).

The catastrophic benefit package differs from the specified benefit package in that it does not cover prenatal care, well baby care, and mental health services. In addition, the deductible under the catastrophic plan would increase from \$250 per person and \$500 per family to \$2,000 per person and \$5,000 per family.

**Number of people affected.** The number of uninsured persons who become covered remains the same since only the benefit package changes. However, the currently insured are not affected because employers would not be required to upgrade benefits.

**Costs of the plan.** Employer costs would be substantially less under an employer mandate that requires catastrophic coverage compared to the costs under a specified benefit package. While costs to employers would be \$34.0 billion under the specified benefit package, they would be \$10.5 billion under a catastrophic plan (Table 54). The net cost to employers under the catastrophic mandate would be \$7.1 billion compared to \$24.2 billion under the specified benefit package. Also, a catastrophic plan would not increase costs for employers who currently offer insurance since almost all these firms provide more comprehensive coverage than that required.

## Exhibit 10

### Employer Mandate with Catastrophic Benefits

- **PERSONS COVERED:** Employers are required to provide catastrophic health insurance coverage to employees who work at least 17.5 hours per week and their dependents.
- **EMPLOYERS AFFECTED:** All firms are affected.
- **BENEFITS:**
  - Inpatient and outpatient hospital coverage.
  - Inpatient and outpatient physician services.
  - Laboratory and x-ray services.
  - Prescription drugs.
- **PREMIUMS AND COST SHARING:**
  - Employers must pay 80 percent of the cost of the premium for employees and their dependents with two exceptions:
    - Employers pay the full premium for workers earning less than 125 percent of the minimum wage.
    - Employers are allowed to pay less than 80 percent of the premium for employees who work between 17.5 and 25 hours per week.
  - Employees are required to pay a maximum deductible of \$2,000 per person and \$5,000 per family.
  - Co-insurance is 10 percent for the first \$5,000 above the deductible and 0 thereafter.
  - Persons with catastrophic coverage through their employers would not purchase Medicaid buy-in. Those with nongroup coverage with broader benefits than the catastrophic policy would continue to purchase a nongroup filler policy that maintains the current benefit level within the nongroup coverage.
- **PARTICIPATION:**
  - Participation is mandatory.
  - Spousal waiver allowed.

Table 54

Average Monthly Premiums Under Current Policy  
and Under Two Employer Mandates in 1989

	Persons Covered Under Current Law		Persons Who Become Covered Under Under the Mandate		
	Monthly Premium Under Current Policy	Monthly Premium Under Specified Benefits <sup>a/</sup>	Monthly Premium Under Specified Benefits	Monthly Premium Under Catastrophic Plan	
<u>Single Individuals</u>					
Total	\$92.02	\$93.31	\$66.32	\$30.10	
Employer Share	79.33	83.70	56.26	25.90	
Employee Share	12.69	9.61	10.06	4.20	
<u>Family Coverage</u>					
Total	\$261.21	\$264.86	\$161.47	\$83.06	
Employer Share	202.02	217.32	132.34	67.83	
Employee Share	59.19	47.54	29.13	15.23	
<u>Plan Average Premium</u> (Reflects Single/Family Coverage Mix)					
Total	\$176.86	\$179.34	\$102.86	\$50.82	
Employer Share	140.94	150.42	85.48	42.31	
Employee Share	35.92	28.92	17.38	8.51	

<sup>a/</sup> Estimates reflect increase in number of workers who elect family coverage and increase in employer share of premium.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

One observation that emerges from this analysis is that the premiums needed to cover the currently uninsured are lower than those of the currently insured. This is because the uninsured tend to be younger and have smaller families than the insured. If the currently insured were all covered under the employer mandate with specified benefits the average premium would be \$93.31 for single coverage and \$264.86 for family coverage. Providing the same benefit package to the currently uninsured would result in premiums that are 30 percent (\$68.32) lower for the single coverage and about 40 percent lower (\$61.47) for family coverage (Table 55).

As would be expected, the premiums under the catastrophic benefit package are significantly lower than the specified benefits. Premiums under a catastrophic benefit package would not change for the currently insured since employers would not change their plans and downgrade benefits to conform to the catastrophic benefit package. For the uninsured, the premiums under the catastrophic plan are about one-half the premiums under the specified benefits plan.

The cost of providing health insurance can be viewed in terms of an increase in the hourly compensation per worker. Under the employer mandate with specified benefits, employers would face an increase in the hourly compensation of workers of \$.36 for single employees and \$.81 for employees with dependents (Table 56). Under the catastrophic plan the increase in hourly compensation would be \$.16 for single workers and \$.41 for workers with dependents. With the exception of employees earning less than \$4.25 per hour, where the employer bears the full premium cost, the average employer cost per hour would increase as the employee hourly wage increases. This is because persons with higher wages tend to be older and have larger families than persons with lower wages.

#### d. Employer mandate with Medicaid eligibility and buy-in

While employer mandates would extend coverage to a large number of the uninsured, many would remain uncovered. These would be persons who are unemployed or not in the labor force. Some proposals to establish employer



Table 55

## Impact of Employer Mandate Under Selected Variations in Plan Design

	Persons Who Obtain Obtain Employer Coverage (in millions)			Before Tax Change in Employer Costs (in billions) <sup>a/</sup>		
	Workers and Dependents	Workers	Dependents	All Firms Currently Offer Insurance	Firms That Currently Do Not Offer Insurance	Firms That Currently Do Not Offer Insurance
<b>Employer Mandate</b>	49.7	29.6	20.1	\$34.0	\$12.7	\$21.3
<b>Variations in Mandate</b>						
Exempt firms with 10 or fewer employees	42.5	25.1	17.4	28.0	10.2	17.8
Apply mandate to only full-time (35+ hours) workers	41.3	22.1	19.2	29.2	9.0	20.2
Exclude temporary workers (4-month waiting period)	47.5	28.4	29.1	31.1	11.6	19.5
Exclude dependents	29.6	19.6	0.0	21.3	7.6	13.7
Prohibit spousal waivers (i.e., spouses must take coverage on own job)	49.7	48.3	1.4	35.3	(0.6)	35.9
Reduce premium sharing to 50 percent for dependents	49.7	29.6	20.1	27.3	7.6	19.7
50 percent hospital cost sharing through \$2,500	49.7	29.6	20.1	19.9	3.8	16.1
Use "pay or play" <sup>a/</sup>	27.4	15.2	12.2	29.7	10.6	19.1

<sup>a/</sup> Total employer tax payments under this option would be 8.7 billion.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model.

Table 56  
Monthly Premiums and Employer Costs per Hour for Workers  
Who Became Covered Under Selected Employer Mandates

Type of Coverage	Average Monthly Premium		Average Employer Cost Per Hour	
	Employer Mandate Specified Benefits	Employer Mandate Catastrophic Plan	Employer Mandate Specified Benefits	Employer Mandate Catastrophic Plan
Single Coverage	\$ 66.32	\$30.10	\$0.36	\$0.16
Family Coverage	161.47	83.06	0.81	0.41
<b>Hours Worked Per Week</b>				
17.5 - 34	76.34	30.70	0.52	0.22
35 or more	106.22	53.42	0.54	0.27
<b>Hourly Wage Rate</b>				
Less than \$4.25 <sup>a/</sup>	81.21	50.62	0.39	0.32
\$4.25 - \$5.99	64.73	39.13	0.32	0.19
\$6.00 - \$9.99	85.64	40.40	0.41	0.20
\$10.00-\$14.99	87.23	44.33	0.42	0.24
\$15.00 or more	156.51	94.79	0.75	0.45
<b>ALL WORKERS</b>	\$102.86	\$50.82	0.54	0.26

<sup>a/</sup> Employers are required to pay the full premium for minimum wage workers.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

**Lewin/ICF**

mandates also include provisions for extending insurance to all or a portion of the remaining uninsured. In this analysis we examine the interaction between employer mandates and Medicaid expansion options using the Kennedy-Waxman "Health Benefits for All Americans Act" as a model.

This plan includes an employer mandate with the specified benefit package described above and Medicaid expansions for the remaining uninsured. The Medicaid expansion includes: 1) extending Medicaid coverage to all persons with incomes below the poverty level without regard to categorical eligibility; and 2) establishing a Medicaid buy-in for all other uninsured persons. The buy-in is subsidized for persons with incomes below 185 percent of poverty. We analyzed participation in the Medicaid program assuming full participation as an upper bound and less than full participation using our enrollment model (Exhibit 11).

Number of people affected. Currently 23.3 million persons are enrolled in Medicaid. Under the expansion modeled here, an additional 15.9 million persons would enroll (assuming less than full participation) so that those enrolled in Medicaid at some point in the year would be 39.2 million persons (Table 57).<sup>8</sup> The employer mandate would affect 49.7 million. These numbers are not additive; some individuals would receive coverage over the course of the year from both Medicaid and employer coverage. Approximately 25 percent of the 25.9 million uninsured persons who become covered under the employer mandate also become covered by the Medicaid buy-in during part of the year.

If full participation is assumed, 26.3 million persons would enroll in Medicaid bringing the total covered by the program over the course of a year to 49.6 million persons. With full participation, enrollment in the Medicaid buy-in would increase almost three-fold.

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<sup>8</sup> Some of these individuals would be enrolled in the program only part year, and of these, some would be enrolled in both an employer plan and Medicaid over the course of a year.

## Exhibit 11

### Employer Mandate with Medicaid Expansion

- **PERSONS COVERED:** All persons can obtain either employer-based insurance or Medicaid. Employers are required to provide health insurance to employees who work at least 17.5 hours per week and to their dependents. Persons who are not covered by an employer plan are eligible for Medicaid if their incomes are below 100 percent of poverty regardless of categorical eligibility. Persons with incomes above 100 percent of poverty who are not covered by employer-based insurance can enroll in a Medicaid buy-in program with an income-related premium.
- **EMPLOYERS AFFECTED:** All firms are affected.
  - Firms that employ fewer than 10 employees or have been in business for less than two years are required to offer the catastrophic plan.
  - Employers with five or fewer employees will be phased-in over five years.
- **BENEFITS:** Same as under the employer mandate with specified benefits.
- **PREMIUMS AND COST SHARING:**
  - Mandate:**

Employers must pay 80 percent of the premium except for workers earning less than 125 percent of the minimum wage for whom they pay the full premium.

    - Deductibles are \$250 for individual coverage and \$500 for family coverage.
    - No cost sharing for prenatal care and well-baby care.
    - Co-insurance may not exceed 20 percent.
  - Medicaid and Medicaid buy-in:**
    - No premium for persons below 100 percent of poverty.
    - For workers with incomes under 100 percent of poverty who are covered by an employment-based plan, Medicaid would pay their copayments, deductibles, and premiums.
    - Persons between 100 and 185 percent of poverty could incur cost sharing up to 10 percent of their income. The premium share would be 5 percent of income. Deductibles are \$125 for an individual and \$250 for a family. Coinsurance is 10 percent.



Exhibit 11  
(continued)

Employer Mandate with Medicaid Expansion

-- Individuals above 185 percent of poverty would pay the full cost of the premium.

• PARTICIPATION:

Mandate:

Participation is mandatory for employees who work more than 25 hours per week and their dependents.

-- Employees who work between 17.5 and 25 hours per week may decline coverage if it is more than 5 percent of their income unless they are currently purchasing non-group coverage at a higher premium. Then individuals will accept employer coverage and drop non-group insurance.

-- Spousal waiver allowed.

Medicaid and Medicaid buy-in:

Analyzed with two participation assumptions.

-- Full participation (i.e., all eligible enroll).

-- Less than full participation which assumes those currently eligible do not enroll; newly eligible enroll at the same rate as persons with similar age, sex, income, and health status.

Table 57

Impact of Proposed Medicaid Expansions Implemented  
Together with Employer Mandate Medicaid Expansion

	Average Monthly Enrollment	
	Less Than Full Enrollment <sup>a/</sup>	Full Enrollment <sup>b/</sup>
Persons Enrolled in Medicaid Under Current Policy	23.3	23.3
Raise Income Limits to Poverty Level and Decouple Eligibility	11.8	17.8
Medicaid Buy-In (Subsidized Through 185 Percent of Poverty)	<u>4.1</u>	<u>8.5</u>
Total New Enrollment	<u>15.9</u>	<u>26.3</u>
Total Enrollment	39.2	49.6

<sup>a/</sup> Assumes Medicaid enrollment occurs only if the individual applies.

<sup>b/</sup> Assumes all persons who are eligible for Medicaid enroll.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Individuals' employment and income status changes over time. Many of the uninsured move in and out of employment and may only be uninsured for part of the year. Our analysis permits an examination of this change in status. By calculating eligibility on a month-by-month basis, we can identify changes in status that render persons eligible for multiple coverage over the course of a year.

Our estimates provide an upper bound on Medicaid enrollment. We assume that persons who become unemployed and are eligible for Medicaid for part of the year enroll at the same rate as persons who are eligible for Medicaid all year. However, some part-year eligibles may never enroll in the program because they may expect their change in income to be temporary.

**Costs of the program.** Under the Medicaid expansion, employer costs do not change, while Medicaid program costs increase (Table 58). Employer costs remain unchanged since persons only enroll in Medicaid if they cannot obtain employer-based coverage. The net increase in Medicaid costs would be \$16.3 billion at less than full participation and \$24.1 billion at full participation. The largest increase in costs is attributable to raising the eligibility level to poverty and eliminating categorical eligibility restrictions. The cost of the Medicaid buy-in is very sensitive to assumptions regarding participation.

In addition to the increase in costs for the Medicaid program, federal and state governments would experience a decrease in tax revenues collected from employers who are required to establish health plans. Only the impact on the federal government is analyzed here. This loss of federal and state funds would be offset by a savings to Medicare and CHAMPUS from an increase in employer-based insurance. As a result, with less than full participation in Medicaid total net public costs would increase by \$21.0 billion with \$14.3 billion and \$6.7 billion representing the federal and state share, respectively. The increase in costs would be \$28.8 billion with full participation, with \$18.9 billion and \$9.9 billion representing the federal and state share, respectively (Table 59).

Table 58

Estimated Medicaid Costs Under Combined Employer Mandate with Medicaid Expansion<sup>a/</sup>  
(in millions)

	Less Than Full Participation <sup>b/</sup>	Full Participation <sup>a/</sup>
<b>Change in Program Costs for Current Enrollees</b>		
Medicaid costs under current policy	\$39.1	\$39.1
Savings Resulting Under Employer Mandate	(2.7)	(2.7)
Medically Needy Costs Covered by Buy-In	<u>(5.6)</u>	<u>(5.6)</u>
Medicaid Costs for Current Enrollees Under New Program	30.8	30.8
<b>New Program Costs</b>		
Raise Eligibility Limit to Poverty Level and Decouple Eligibility	15.4	17.5
<b>Medicaid Buy-In</b>		
Medically Needy Shifted to Buy-In	5.6	5.6
Other New Enrollees	6.2	17.6
Less Premium Payments	<u>(2.6)</u>	<u>(8.2)</u>
Net Cost of Buy-In	<u>9.2</u>	<u>15.0</u>
Total New Medicaid Program Costs	<u>24.6</u>	<u>32.5</u>
<b>Total Cost Under New Program</b>	55.4	63.3
<b>Net Increase in Medicaid Program Costs</b>	\$16.3	\$24.1

<sup>a/</sup> Includes benefit and administrative costs.

<sup>b/</sup> Assumes individuals enroll in the Medicaid program based upon individual preference.

<sup>c/</sup> Individuals are required to participate during months where uninsured.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

**Lewin/ICF**



Table 59

Total Federal and State Costs Under the Employer Mandate with Medicaid Expansion  
(in billions)

	<u>Less Than</u> <u>Full Medicaid Participation</u>			<u>Full</u> <u>Medicaid Participation</u>		
	<u>Total</u> <u>Cost</u>	<u>Federal</u> <u>Share</u>	<u>State</u> <u>Share</u>	<u>Total</u> <u>Cost</u>	<u>Federal</u> <u>Share</u>	<u>State</u> <u>Share</u>
Employer Mandate						
Tax Expenditure	\$ 7.2	\$7.2	a/	\$7.2	\$7.2	a/
Medicare Savings as Secondary Payor to Employer Coverage	(1.7)	(1.7)	--	(1.7)	(1.7)	--
Savings to CHAMPUS	(0.8)	(0.8)		(0.8)	(0.8)	
Medicaid Expansions	<u>16.3</u>	<u>9.6</u>	<u>6.7</u>	<u>24.1</u>	<u>14.2</u>	<u>9.9</u>
Total Net Cost	\$21.0	\$14.3	\$6.7	\$28.8	\$18.9	\$9.9

a/ Not estimated.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

## 2. "Pay or Play" Tax Incentives

Our analysis of "pay or play" tax incentives is based on the plan proposed by The National Leadership Commission on Health Care (NLCHC) which would assure that all Americans have health insurance. The proposal consists of an employer tax incentive and a public health insurance fund. The plan uses a system of tax penalties to encourage employers to offer health insurance coverage to their workers and dependents. All persons who are not covered through their employer and are without insurance from some other source would be covered under a health insurance fund established under the plan. Medicaid would be restructured to be a long-term care program and persons formerly covered under Medicaid would be covered under the fund.

### a. Description of the plan

**Employer tax incentive.** The employer component of the NLCHC plan is designed to encourage employers to offer adequate health insurance coverage. The plan would impose a tax of 9.6 percent of employee payroll on employers who do not provide health insurance which meets the NLCHC benefits standard. To have the tax waived, employers must offer coverage that provides a basic level of services with limited coinsurance levels specified by the plan. The benefit package would cover inpatient hospital care (30 days maximum for mental health), physician services, drugs, and outpatient care with a \$100 per person deductible, 20 percent coinsurance and a maximum cost sharing limit of \$1,000 (\$3,000 for families). The employer would also be required to pay a minimum of 75 percent of the cost of purchasing this specified level of benefits.

Employers who do not offer health insurance would pay the tax on all employees. Employers who provide health insurance but exclude certain classes of workers, such as part-time workers, would pay the tax on all workers excluded under the plan. In addition, employers offering plans which fall below the benefits standard would be required to pay the full amount of the

tax (i.e., the tax payment is not pro-rated for the amount of coverage provided).

Although the latest version of the NLCHC proposal permits spousal waiver, we have modelled pay or play assuming that spouses are required to take primary coverage under their employer's plan or the fund if their employer opts to pay the tax. Thus, a worker who is covered as a dependent on his/her spouse's employer health plan must now be covered through his/her own employer. This provision would shift primary responsibility for covering working spouses from employers who now offer coverage to employers who do not offer health insurance coverage. Employers currently providing more generous benefits to dependents than the minimum required by the plan could hold their employees harmless by providing wraparound coverage and premium contributions that reduce the employee liability to current levels. This would preserve employee goodwill while reducing the employer's costs. In our modeling, we have assumed that employers do this.

The plan analyzed also requires that in cases where two spouses are working, dependent children would be allocated across the plans offered by the two employers. This would be done using a random allocation process where on average each plan is assigned responsibility for half of the children a couple may have. Thus, this proposal would result in a shift in responsibility for covering some non-working dependents away from existing employers to employers who do not now offer health insurance.

These inter-employer equity provisions would shift some persons away from coverage under existing plans to coverage under the public insurance fund. This is because some of the employers who do not now offer insurance may choose to pay the tax and cover their workers and dependents under the fund rather than offer a health insurance plan. In these instances, the inter-employer equity provisions could actually reduce the number of persons with employer sponsored coverage.

It is also possible that the plan would encourage some employers to discontinue their health plans. The reason for this is that in a labor market characterized by universal health insurance coverage, all persons would have health insurance regardless of whether their employer offers a plan. Therefore, employers may no longer need to offer health insurance to attract workers. Consequently, some employers may terminate their health plans and cover their workers under the fund by paying the tax in instances where the tax payment is less than the cost of insurance. If the tax is set at the average cost of providing insurance, paying the tax in lieu of offering insurance will be less costly for many employers.

**Modeling tax incentives on employers.** We assume that the employers' response to the tax incentive would be to minimize their costs. Thus, employers would compare their premium costs under the plan to what they would pay if they did not offer insurance and decide whether to offer insurance on the basis of which is least costly. In addition, we assume the employer would make the decision about whether to offer insurance separately for part-time and full-time workers. Exhibit 12 summarizes the specifics of the plan. In this analysis we used the following specific assumptions:

- Employers who now offer insurance but exclude part-time workers from the plan would continue to exclude part-time workers employed for 20 or fewer hours per week and cover these workers under the fund by paying the tax (it is assumed that the tax payment on part-time workers would generally be less costly than providing insurance).
- Employers who currently offer health insurance would terminate their health plans in instances where total tax payments for the firm would be less than total plan premium payments if they offered the specified health insurance coverage.
- Employers who do not currently offer health insurance would provide health insurance coverage to full-time workers only in cases where the cost of purchasing this coverage for their workforce is less than the cost of paying the tax.
- Employers who do not currently offer health insurance would not provide insurance to part-time workers employed for 20 or fewer hours per week regardless of whether they decide to cover full-time workers and would pay the tax on part-time employees.



## Exhibit 12

### "Pay or Play" Based on National Leadership Commission on Health Care

#### Employer-based Coverage

- **Persons Covered:** Employers are required to provide health insurance to employees who work 25 hours or more per week and their dependents or pay a 9.6 percent tax which approximates the cost of insurance.
- **Employers Affected:** All firms are affected.
- **Benefits:**
  - Basic Package
    - Inpatient and outpatient hospital coverage
    - Inpatient and outpatient physician coverage
    - Laboratory and x-ray services
    - Prenatal care
    - Prescription drugs
    - Psychiatric inpatient care (limit of 30 days)
    - Psychiatric outpatient care (limit of 50 visits)
  - Catastrophic limit of \$1,000 per person and \$3,000 per family
  - Employees may not be excluded because of pre-existing conditions.
- **Premiums and Cost Sharing:**
  - Employers must pay 75 percent of the cost of the premium for employees and their dependents.
  - Employees will accept coverage if the cost does not exceed 5 percent of income.
  - Employees would have a \$100 deductible and 20 percent co-insurance; outpatient mental health services have 50 percent co-insurance.
  - Spousal waiver prohibited.

Exhibit 12  
(continued)

"Pay or Play" Based on  
National Leadership Commission on Health Care

■ Participation:

- Employers provide insurance if it is less than paying the tax.
- Employees accept coverage if it is less than 5 percent of their income and less than obtaining coverage from the fund.

Public Fund

- Eligibility: All persons not covered by employment-based insurance must enroll or have nongroup coverage.
- Benefits: Same as under the employer-based plan.
- Premiums and Cost Sharing:
  - No premium or cost sharing for persons below 150 percent of poverty.
  - Persons above 150 percent of poverty pay a premium that does not exceed 5 percent of their income.
  - Persons above 150 percent of poverty have \$100 deductible and 20 percent co-insurance; outpatient mental health services have 50 percent co-insurance.
- Participation: Participation is mandatory.

We assume that all employer health plans would conform to the specified benefits and premium sharing requirements under the plan. This assumption is reasonable given that the cost of bringing existing plans into compliance would generally be less than the cost of paying the tax. Thus, all existing employer plans that fall below these standards would be upgraded accordingly. Further, all newly established employer plans would provide the benefit package in order to be exempt from the tax.

**b. Impact of the "pay or play" proposal**

**Impact on employer coverage.** About 144.1 million persons are covered under employer health plans. Under the pay or play proposal, the number of workers and dependents with employer-financed health insurance would increase to about 195.5 million persons, including 168.5 million covered under employer-sponsored health plans and about 27.0 million covered under the fund by employers who pay the tax rather than offer insurance (Table 60).

Because of the spousal waiver limits, this plan would reduce the number of persons covered under existing plans. For example, the number of workers and dependents covered under plans which would have been sponsored under current law would decline from 144.1 million under current policy to 119.6 million. About 20.5 million working dependent spouses would become covered through their own employer under the plan. Of these, about 13.7 million would become covered under newly established plans and about 6.8 million would become covered under the fund by employers who pay the tax rather than provide insurance. In addition, about 4.8 million dependent children would be allocated to the working dependent spouse's employer with 2.3 million covered under newly established plans, 1.2 million covered under the fund, and 1.3 million covered under existing plans.

As discussed above, we also assume that some employers who offer health insurance under current policy will terminate their plans and cover their workers under the fund. This would result in about 4.2 million workers and about 1.2 million dependents becoming covered under the fund.

Table 60

Impact of Pay or Play Plan on Sources of Insurance for Workers and Dependents in 1989  
(in millions)

	Coverage Under Pay or Play Proposal			
	Total Persons	Workers and Dependents Covered Under Existing Plans	Workers and Dependents Who Become Covered on Newly Established Employer Plans	Workers and Dependents Who Become Covered Under Fund
Workers and Dependents in Firms Who Sponsor Health Insurance Under Current Policy				
Covered workers	69.9	65.7	N/A	4.2
Covered Working Dependent Spouses <sup>a/</sup> Working Dependent Spouses <sup>b/</sup> Children in Families with Working Spouses <sup>c/</sup>	20.5 4.8	0.0 1.3	13.7 2.3	6.8 1.2
Other Covered Dependents	51.4	50.2	0.0	1.2
Workers and Dependents Excluded from Plan Under Current Policy <sup>d/</sup>	8.4	2.4	0.0	6.0
Workers and Dependents in Firms That Do Not Now Offer Health Benefits <sup>e/</sup> (Excluding workers and dependents covered as dependents on existing plans.)	24.9	N/A	19.7	5.2
Workers	15.6	N/A	13.2	2.4
Dependents	9.3			
Total	195.5	119.6	48.9	27.0

<sup>a/</sup> Employers are permitted to terminate their health plan and cover workers under the fund by paying the tax.<sup>b/</sup> Working dependent spouses are required to take coverage on their own job.<sup>c/</sup> Dependent children are to be allocated among employer plans in cases where both parents are employed.<sup>d/</sup> Firms that now offer insurance will be required to cover part-time workers and their dependents.<sup>e/</sup> Employers that do not now offer health insurance will be required to either offer insurance or pay the tax.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



Although the total number of persons covered by firms that currently offer insurance would decline under the plan, these firms would become responsible for insuring persons who are currently excluded from existing plans. About 8.4 million workers and dependents who are excluded from coverage under an employer plan would become covered in firms that currently offer health insurance. Of these, 2.4 million would become covered under the existing plan while employers would finance coverage for the remaining 6.0 million persons under the fund.

While the number of persons covered under existing employer health plans would decline by about 24.5 million, the number of persons covered under newly established health plans would be 48.9 million. This represents a net increase in the number of workers and dependents covered under employer sponsored health plans of 24.4 million persons (Table 61).

**Persons affected by "pay or play" plan.** All of the currently uninsured would be covered under this plan, one-half by an employer plan and one-half under the fund. Overall the source of insurance coverage would change for another 105.2 million persons, about 46 percent of whom would become covered under employer-sponsored health insurance (Table 62).

Over 70 percent of the 105.2 million persons who are affected by the plan are currently insured. About 14 percent of Medicaid enrollees would now obtain employer-based insurance, while the remainder would become covered under the fund. Among those with non-group insurance, about two-thirds would discontinue this insurance and become covered by employer-based insurance while one-third would become covered under the fund. About 5.4 million persons formerly covered under employer plans would become covered under the fund as some employers terminate their plans. Finally, 24.0 million of those whose coverage would change under the plan would be persons affected by inter-employer equity provisions.

Table 61  
Change in Employer Coverage Under Pay or Play Plan

	Firms Offering Insurance Under Current Policy	Firms Establishing Health Insurance Plans	Net Impact on Employer Coverage
Workers and Dependents Covered Under Current Policy	144.1	--	144.1
Workers and Dependents in Firms that Terminate Coverage	(5.4)	--	(5.4)
Dependents Shifted to Other Plans	(24.0)	16.0	(8.0)
Persons Who Become Covered Under Employer Plans	<u>4.9</u>	<u>32.9</u>	<u>37.8</u>
Total Enrollment	<u>119.6</u>	<u>48.9</u>	<u>168.4</u>
Net Change in Employer Plan Coverage	(24.5)	48.9	24.4

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 62

Persons Potentially Affected by the Pay or Play Plan  
by Source of Coverage Under Current Policy  
(in millions)

	Persons Potentially Affected by Pay or Play Plan	Persons Who Become Covered Under Employer Plan	Persons Who Become Covered Under Fund
Uninsured Under Current Policy	31.5	16.1	15.4
Insured by Medicaid Under Current Policy <sup>a/</sup>	23.3	3.3	20.0
Insured Through Non-Group Insurance Under Current Policy	21.0	13.5	7.5
Workers and Dependents in Employer Plans Shifted to Fund <sup>b/</sup>	5.4	--	5.4
Working Spouses and Dependent Children Shifted Out of Existing Employer Plans <sup>c/</sup>	<u>24.0</u>	<u>16.0</u>	<u>8.0</u>
Total	105.2	48.9	56.3

<sup>a/</sup> Non-institutionalized Medicaid participants are transferred to the fund under the pay or play proposal.

<sup>b/</sup> Employees are permitted to terminate their plans and cover individuals under the fund by paying the tax.

<sup>c/</sup> Working dependent spouses who are covered by employer plans now become covered through their own employer, some of whom will cover these workers under the fund by paying the tax. Dependent children are also allocated across the patient's plans in cases where both spouses are working.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Many persons would also be covered under the fund for part of the year. In general, this would occur during periods of the year when the individuals are unemployed and not covered by an employer health plan. About 75.2 million persons would participate in the fund sometime during the year (Table 63). Average monthly enrollment under the fund is estimated to be 66.1 million persons.

**Impact on employer costs.** In general, with spousal waiver limits, the plan would result in a reduction in costs for employers who now sponsor insurance while increasing employer costs for those who do not now offer coverage. The total change in employer costs would be an increase of \$18.3 billion. Employers who currently offer insurance would have a reduction in costs of \$14.5 billion, while costs to employers who do not provide insurance would increase by \$32.8 billion. The total after tax (i.e., accounting for the tax deductibility of health premium payments) net change in employer costs would be a reduction in costs for employers who offer insurance under current law of about \$11.2 billion and an increase in expenditures by firms that do not now offer health insurance of about \$25.3 billion. Overall, total net employer expenditures for health benefits would increase by about \$14.1 billion under the plan.

The plan would affect employer costs in firms that now offer health insurance in several ways. Costs to employers who now offer insurance would increase by \$8.4 billion to cover part-time workers and dependents and to upgrade their health plans to conform to the standard benefit and premium sharing provisions of the plan. Employers who decide to pay the tax rather than offer insurance for some or all of their workers would face tax payments of \$7.2 billion. At the same time, the costs to employers currently offering insurance would be reduced by about \$23.2 as a result of the inter-employer equity provisions of the plan. Employers who terminate their plan and cover workers under the fund would save \$1.4 billion.

Employers who now offer insurance would have savings in premium costs attributed to a reduction in charity care overhead charges by providers. As discussed above, providers generally include in their charges, either



Table 63

Persons Covered Under the Fund  
(in millions)

	Number of Persons
Persons Covered Sometime During Year <sup>a/</sup>	75.2
Persons Covered All Year	56.3
Average Monthly Enrollment	66.1

<sup>a/</sup> Persons who are covered under the fund in any month where individuals are without insurance coverage from any other source.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

explicitly or implicitly, an overhead charge to cover the cost of bad debt and charity care. Because uncompensated care expenses by providers would be reduced under a universal coverage system, we assume that these reductions would be passed on to purchasers of insurance in the form of reduced premiums. We estimate that employers who now provide insurance would save about \$5.5 billion from reduced uncompensated care costs.

Among employers who do not now offer insurance, total health plan costs would increase by \$32.8 billion. This includes an increase in health benefits under the plan of \$28.2 billion and tax payments of \$4.6 billion (Table 64). These increases in employer costs would be offset by tax savings of \$7.5 billion due to the deductibility of employer health benefits payments in determining corporate income tax liability.

#### c. Expenditures and revenues under the fund

Financing is an integral part of a "pay or play" approach. One of the challenges in designing the fund is to set the tax rate to assure that the revenue raised from the employer tax is adequate to serve those who become covered under the fund. Our analysis indicates that the employer and employee tax revenue will not provide the financing needed to support the fund.

Total expenditures under the fund would be about \$91.6 billion. These include benefit payments of \$86.4 billion and administrative costs of \$5.2 billion (Table 65).

The fund would be financed by revenues from several sources. First, the fund would obtain about \$11.8 billion in revenues from the tax penalty payments by employers who fail to offer insurance. Second, individuals participating in the fund would pay a tax of 2.1 percent of adjusted gross income, bringing in revenues of \$6.0 billion. Third, \$39.0 billion in funds that would have been used to finance benefits under the Medicaid program would be transferred to the fund.

Table 64

Change in Employer Costs Under Pay or Play Proposal  
(in billions)

	Firms That Offer Insurance Under Current Policy	Firms That Do Not Offer Insurance Under Current Policy	All Firms
<u>Total Employer Health Plan Cost</u>	\$114.0	--	\$114.0
<u>Increase in Employer Costs</u>			
Increase in Health Plan Costs Under Proposal <sup>a/</sup>	8.4	\$28.2	36.6
Savings Due to Plan Terminations <sup>b/</sup>	(1.4)	--	(1.4)
Savings Due to Spouses Coverage on Own Job	(23.2)	--	(23.2)
Total Tax Payments Under Policy <sup>c/</sup> (for workers not covered under plan)	7.2	4.6	11.8
Charity Care Savings Offset <sup>d/</sup>	<u>(5.5)</u>	<u>--</u>	<u>(5.5)</u>
<u>Total Employer Cost Under Policy</u>	\$ 99.5	\$32.8	\$132.3
Net Change in Cost	(14.5)	32.8	18.3
Tax Savings Offset	<u>3.3</u>	<u>(7.5)</u>	<u>(4.2)</u>
<u>Total After Tax Net Change in Employer Cost</u>	(\$11.2)	\$25.3	\$ 14.1

<sup>a/</sup> Reflects increase in premium payment by employer (the employer is required to pay 75 percent of the premium), the cost of complying with the minimum benefits standard, and the cost of insuring part-time workers.

<sup>b/</sup> Employers are permitted to terminate their health plan and cover workers and dependents under the fund by paying the tax. The savings for firms that exercise this option are computed as the difference between the employer premium payment under current policy and taxes paid for persons shifted to the fund.

<sup>c/</sup> Employers who do not offer health insurance are required to pay an employer tax of 9.7 percent of payroll. Includes tax payments by employers who terminate their plan and transferred their workers and dependents to the fund.

<sup>d/</sup> The NLCHC universal health care proposal will reduce charity care overhead charges by providers which are assumed to be reflected in health plan premiums.

<sup>e/</sup> We assumed an average marginal corporate tax rate of 23 percent.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

**Lewin/ICF**

Table 65

Expenditures and Revenues Under Insurance Fund in 1989<sup>a/</sup>

Expenditures		Revenues	
Benefit Payments	\$86.4	Employer Tax Payment <sup>e/</sup>	\$11.8
Administrative Costs <sup>b/</sup>	5.2	Tax Payment by Persons <sup>e/</sup> Covered Under Fund	6.0
		Medicaid Funding <sup>d/</sup> (maintenance of effort)	39.1
		Federal	21.8
		State Share	17.3
		Revenues to be Collected <sup>f/</sup> Under Earmarked Tax	34.7
Total Expenditures	\$91.6	Total Revenues	\$91.6

<sup>a/</sup> Includes non-institutionalized persons only.

<sup>b/</sup> Assumes administrative expenses equal to six percent of benefit payments.

<sup>c/</sup> Tax on employers who do not provide insurance.

<sup>d/</sup> Medicaid is abolished for non-institutionalized persons under the NLCHC proposal. Medicaid participants and funding are transferred to the fund under the pay or play proposal. We assume that Medicaid will continue for institutionalized persons.

<sup>e/</sup> Persons who are covered by the fund pay a tax of 2.1 percent of income over 150 percent of the poverty level as a premium.

<sup>f/</sup> The NLCHC establishes two taxes -- a tax on all individual income and a tax on corporate taxes -- to raise the funds not raised through Medicaid funding and the employer and employee taxes on uninsured persons.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



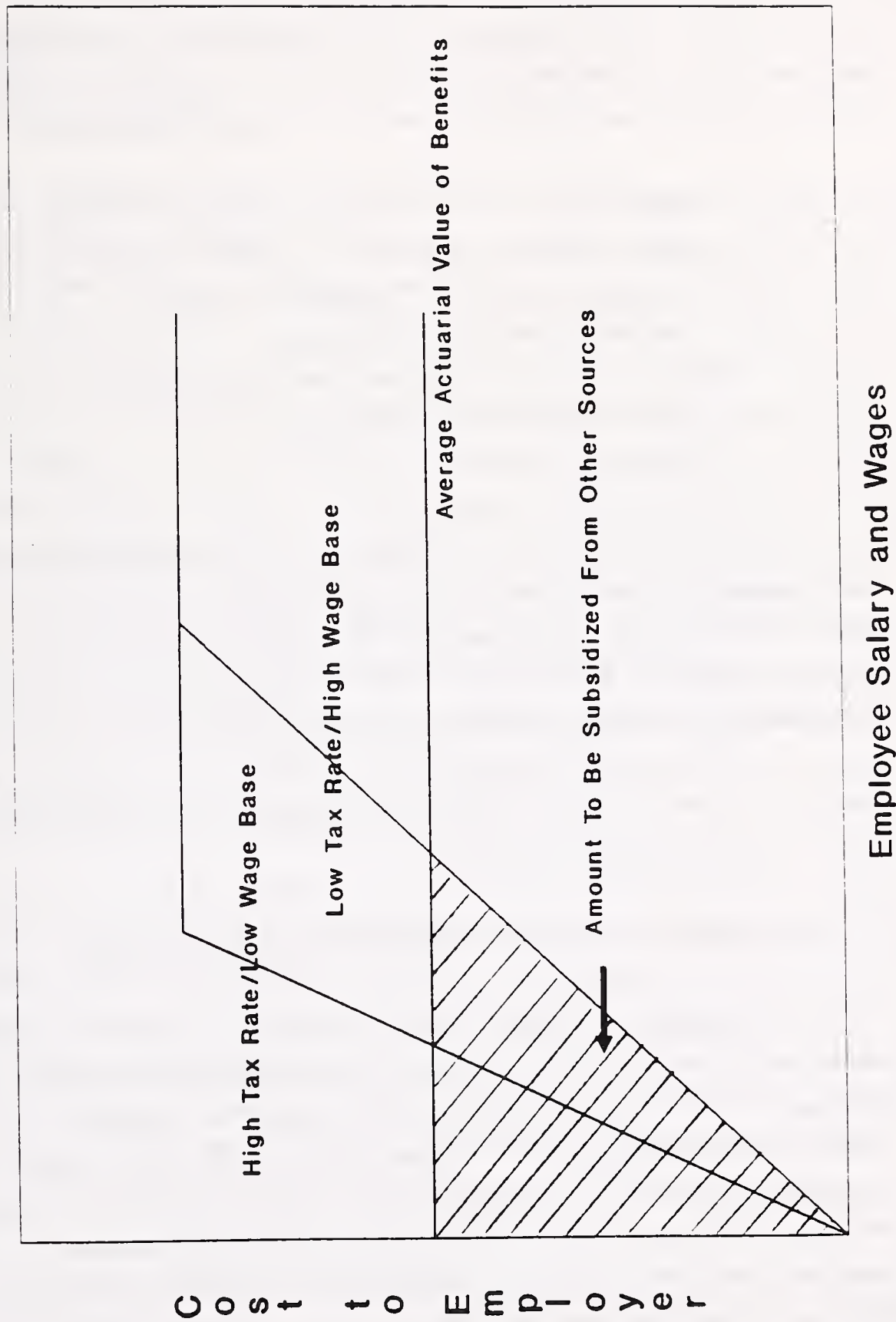
The plan would require an additional \$34.7 billion in revenue to finance expenditures under the fund. About \$7.9 billion represents the increase in Medicaid payment rates to market rates under the fund. The remaining \$26.8 billion shortfall is larger than the funds raised from both the tax penalty and the individual income tax. This occurs for three reasons:

- Coverage by the fund of non-working uninsured requires additional sources of funds. These persons are not employed and therefore have not had a tax payment made by employers to help cover them under the fund. This coverage costs an additional \$19.2 billion.
- The tax rate is set at the average premium. Some employers confront higher than average premiums because of the demographic and health status characteristics of their workforce. These firms might choose to pay the tax and transfer their workers into the fund rather than provide insurance. This results in the fund absorbing a higher proportion of persons of above average cost, and thereby raises the cost of the fund. The tax revenue raised from the employers is below the cost of covering those workers under the fund.
- The tax as a percent of payroll is often less than the actuarial value of benefits. A disproportionate share of low-income workers are brought into the fund because the cost of the tax is less than providing insurance for these workers. As is illustrated in Figure 17, when the tax is collected as a percentage of salary and wages, the tax that must be paid for lower income workers is less than the actuarial value of benefits. This shortfall can be reduced by using a lower wage base and higher tax rate. (The extreme version of this is a fixed amount per employee regardless of salary.) It should be kept in mind, however, that the higher the cost relative to salary, the greater the pressure on employers to reduce their employment of lower income workers or restrict wage increases. Designing pay or play plans require a balance of these considerations in setting the payroll tax rate/wage base. We have estimated the shortfall for employed persons due to these factors at \$7.6 billion.

The NLCHC proposed obtaining these funds from an employer payroll tax regardless of whether the employer offers insurance, and a tax on individual income. The tax rates would be set so that equal amounts of revenues would be obtained from both sources. Other sources of financing could be substituted for these under a "pay or play" approach.

FIGURE 17

# RELATIONSHIP OF EMPLOYER PAYMENTS AND EMPLOYEE SALARY UNDER "PAY OR PLAY" TAX INCENTIVE PLANS



#### D. COMPARISON OF ALTERNATIVE PROPOSALS

The previous sections examined the cost of each approach modeled and the number of people affected. This section provides a comparative analysis of five of these options along several critical dimensions:

- Impact on the total number of uninsured persons.
- Impact on the utilization of health services.
- Changes in sources of payment for care.
- Changes in family expenditures.
- Impact on the health care delivery system.
- Impact on employment and wages.
- Target efficiency.

The five options compared are: 1) the illustrative Medicaid expansion proposal which includes raising the eligibility level to 100 percent of poverty for all persons regardless of categorical eligibility, covering pregnant women and infants with incomes below 185 percent of poverty, and establishing mandatory medically needy programs in all states; 2) the Medicaid buy-in; 3) the employer mandate with two alternative benefit packages; 4) the employer mandate coupled with Medicaid eligibility expansions and a buy-in; and 5) the pay or play approach.

##### 1. Impact on the Total Number of Uninsured Persons

The options analyzed vary to the extent they cover the currently uninsured. Some options, such as selected Medicaid expansion options, are designed to cover high priority groups among the uninsured (e.g., pregnant women and children). Other options, such as the pay or play approach, are designed to cover all or nearly all of the uninsured. The number of persons who remain uninsured under each of the health care expansion options ranges from zero under both the employer mandate with Medicaid expansion (assuming full participation) and the "pay or play" proposal to 24.6 million or 78 percent of the currently uninsured under the illustrative Medicaid option



(Table 66). Under an employer mandate with Medicaid expansions (assuming less than full participation) 2.7 million persons would remain uninsured. Under an employer mandate with no other expansions in coverage 6.2 million persons (19 percent) remain uninsured. Finally, the Medicaid buy-in would leave 21.3 million persons uninsured.

The impacts of these proposals differ in the income and age groups among the uninsured most likely to receive coverage. The proportion of the uninsured covered under the illustrative Medicaid expansion option decreases as family income increases. In contrast, the proportion of uninsured covered under an employer mandate increases as family income increases, with the greatest increase in coverage among families earning more than \$15,000 annually. Looking at change of coverage by age, the proportion of uninsured covered under the illustrative Medicaid expansion option would decrease with age. This is not surprising given the inclusion of infants in families with incomes up to 185 percent of poverty and the elimination of categorical requirements which enables intact families to enroll in Medicaid. Under the employer mandate, coverage would increase with age up to age 44 and then would decrease, with the greatest increase in coverage among persons ages 35 to 44.

#### Impact on the Utilization of Health Services

As the uninsured become covered by health insurance their utilization of health services would be expected to increase. To the extent that this increase represents greater access and appropriate use of services, this may be one of the chief benefits of expanding health coverage. Under all the options health care expenditures would increase, with the largest increases in those options that cover the most people (Table 67). Total new health care expenditures under each of the plans range from \$2.4 billion under the Medicaid buy-in proposal to \$19.2 billion under the pay or play proposal.

The employer mandate with Medicaid expansion (assuming full participation) would result in \$11.3 billion in new health care expenditures, while the NLCHC proposal which covers the same number of uninsured results in almost



**Table 66**  
**Impact of Selected Health Insurance Expansion Proposals on the Number of Uninsured Persons**  
**(in thousands)**

	Uninsured Under Current Policy	Persons Who Remain Uninsured				Employer Mandate with Medicaid Expansion <sup>d/</sup>
		Illustrative Medicaid Expansions Covering Persons in Poverty and Pregnant Women Through 185% Poverty <sup>a/</sup>	Medicaid Buy-In Proposal <sup>b/</sup>	Employer Mandate <sup>c/</sup>		
<b>TOTAL</b>	31,554	24,631	21,284	6,221		2,726
<b>Family Income</b>						
Less than \$10,000	8,846	4,535	3,801	3,458		801
\$10,000 - \$14,999	4,492	3,420	2,460	808		500
\$15,000 - \$19,999	3,996	3,171	2,612	625		294
\$20,000 - \$29,999	5,012	4,511	3,917	554		436
\$30,000 - \$39,999	3,101	2,989	2,942	229		223
\$40,000 - \$49,999	2,537	2,533	2,194	157		140
\$50,000 or more	3,570	3,472	3,358	390		332
<b>Sex</b>						
Males	16,865	12,999	11,285	3,057		1,255
Females	14,689	11,632	10,000	3,164		1,471
<b>Age</b>						
Under 18	8,573	7,189	5,995	1,665		877
18 - 24	5,798	4,142	3,889	993		434
25 - 34	7,575	5,712	4,983	1,060		287
35 - 44	3,671	2,988	2,494	449		184
45 - 54	3,288	2,667	2,201	785		335
55 +	2,649	1,933	1,722	1,269		627

<sup>a/</sup> The policy would extend Medicaid coverage to all persons with incomes below the poverty level (185 percent for pregnant women and infants) and decouple Medicaid eligibility from public assistance eligibility. The assets limit is set at \$5,000, medically needy programs are established in all states, and individuals are certified for six-month periods.

<sup>b/</sup> All persons with income in a month below 185 percent of poverty are eligible to participate in a subsidized Medicaid buy-in program.

<sup>c/</sup> The employer mandate requires employers to cover workers and dependents where the worker is employed 17.5 hours per week or more.

<sup>d/</sup> This policy assumes that enrollment in Medicaid and Medicaid buy-in is optional.

Table 67

Change in Expenditures by Type of Health Care Service for Non-institutionalized Persons  
Under Selected Health Insurance Coverage Expansion Proposals in 1989<sup>a/</sup>  
(in billions)

	Total Health Expenditures Under Current Law	Illustrative Medicaid Expansion <sup>b/</sup>	Medicaid Buy-In	Change in Health Expenditures			Pay or Play Approach
				Specified Benefits	Employer Mandate Catastrophic Benefits	Employer Mandate with Medicaid Expansion <sup>c/</sup>	
Hospital Inpatient	\$167.6	\$1.0	0.7	4.0	\$1.6	5.4	8.2
Hospital Outpatient	34.8	0.3	0.6	0.9	0.2	1.3	2.2
Physicians Care	131.5	0.5	0.7	2.4	0.6	3.3	4.8
Other Professional	16.1	0.1	0.1	0.1	0.0	0.3	0.8
Dental Care	44.6	0.0	0.0	0.0	0.0	0.0	0.0
Drugs and Medical Sundries	30.0	0.1	0.2	0.5	0.1	0.8	2.0
Eyeglasses and Appliances	11.1	0.0	0.0	0.0	0.0	0.0	0.3
Other Health Care Services	12.0	0.1	0.1	0.2	0.1	0.2	0.9
Total Health Care Expenditures	\$447.7	\$2.1	2.4	8.1	2.6	11.3	19.2

a/ Includes health benefit payments only. Excludes administrative costs.

b/ This Medicaid expansion includes raising the eligibility level to the poverty level (185 percent for pregnant women and infants), decoupling eligibility from public assistance, mandating medically needy programs in all states and raising the asset eligibility limit to \$5,000.

c/ Assumes full participation in Medicaid during months when persons are not insured.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

\$19.2 billion in new health care expenditures. This difference is due to a provision in the NLCHC proposal that would increase provider reimbursement rates for those currently covered by Medicaid to market rates as this population becomes covered under the public fund. The increase in health care expenditures attributed to induced demand would be \$11.3 billion under both proposals. This represents an increase in expenditures of 34 percent over current spending by the uninsured.

The employer mandate with a specified benefit package would result in an \$8.1 billion increase in expenditures, while the catastrophic benefit package would limit this increase to \$2.6 billion. This difference is due to the variation in services covered under each proposal, with the catastrophic plan being substantially less comprehensive than the specified benefit package.

Utilization of all services would increase under each proposal (Table 68). The percent of persons with physician visits would increase .1 percent under the illustrative Medicaid proposal and .8 percent under the universal coverage proposals. Physician visits would increase to a greater extent under all proposals than would visits to hospital outpatient departments and emergency rooms.

Plans to extend health insurance to the uninsured would refinance a large portion of the health care that is currently provided to these populations. Extending insurance coverage to all the uninsured would result in total induced demand of \$11.3 billion under both universal coverage proposals. However, under an employer mandate plus Medicaid expansion, new spending by employers would be \$26.4 billion and new spending by government would be \$17.7 billion. The amount in excess of the \$11.3 billion of new services represents the refinancing of services currently being provided to the uninsured and those insured whose coverage is changed. Thus, the amount of health care spending that would be refinanced under this plan exceeds the cost of the new health services. The large amount of refinancing of current services that

Table 68

Changes in Rates of Health Services Utilization for Non-Institutionalized Persons  
Under the Age of 65 Under Selected Health Coverage Expansions Proposals in 1989<sup>a/</sup>  
(in billions)

	Current Policy	Illustrative Medicaid Expansion <sup>b/</sup>	Medicaid Buy-In	Employer Mandate		Employer Mandate with Medicaid Expansion <sup>c/</sup>	Pay or Play Approach
				Specified Benefits	Catastrophic Benefits		
Percent of Persons with Physician Visits	63.9%	64.0%	64.1%	64.3%	64.0%	64.8%	64.8%
Physicians Visits Per 1,000 Persons	2,756	2,779	2,794	2,866	2,770	2,874	2,877
Hospital Admissions Per 1,000 Persons	119	120	119	125	120	126	126
Hospital Outpatient Visits Per 1,000 Persons	581	592	602	617	586	633	634
Emergency Room Visits Per 1,000 Persons	272	274	275	279	273	282	283

<sup>a/</sup> Includes health benefit payments only. Excludes administrative costs.

<sup>b/</sup> This Medicaid expansion includes raising the eligibility level to the poverty level (185 percent for pregnant women and infants), decoupling eligibility from public assistance, mandating medically needy programs in all states and raising the asset eligibility limit to \$5,000.

<sup>c/</sup> Persons are assumed to participate in either Medicaid or the Medicaid buy-in program during months when they are not insured.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



occurs under these options heightens the debate over which payor should bear the cost of extending health insurance to the uninsured.

### 3. Changes in Sources of Payment for Care

Extending health insurance to the uninsured shifts the sources of payment for health care. As noted above, total new health care spending under these proposals would range from \$2.4 billion to \$11.3 billion, but the amount of care that is refinanced would be substantially greater. This section discusses how this care is refinanced and what sources would pay for this care.

Household out-of-pocket spending would decrease under any option, as: 1) services that the uninsured pay for out-of-pocket would become covered under employer insurance or Medicaid; 2) the increase in employer premium share reduces this expense for some insureds; and 3) higher Medicaid eligibility levels reduce out-of-pocket spend down expenses.

The largest decrease in out-of-pocket payments (\$16.9 billion) would occur under a policy of employer mandate coupled with Medicaid expansions, largely because of the Medicaid expansion. The employer mandate alone would reduce out-of-pocket spending by \$5.0 billion. The "pay or play" plan would reduce it by \$12.4 billion. The illustrative Medicaid expansion option also would reduce out-of-pocket spending by \$7.4 billion. The Medicaid buy-in would reduce out-of-pocket spending by \$6.2 billion (Table 69).

The costs to employers increase under each of the employer mandate options. Under the employer mandate, costs to employers would increase by \$29.5 billion, a 21 percent increase over current spending. When Medicaid expansion is implemented with an employer mandate, employer costs decrease as some employees opt for Medicaid coverage instead of the employer coverage. Employer costs would be substantially less under the pay or play because while employers contribute to the coverage of more people via premiums and tax

Table 69

Change in Sources of Payment for Health Care for Non-Institutionalized  
Persons Under Selected Health Insurance Coverage Expansions Proposals in 1989<sup>a/</sup>  
(in billions)

	Total Health Expenditures Under Current Law	Illustrative Medicaid Expansion <sup>b/</sup>	Change in Health Expenditures				Pay or Play
			Medicaid Buy-In	Employer Mandate Specified Benefits	Employer Mandate Catastrophic Plan	Employer Mandate with Medicaid Expansion <sup>c/</sup>	
Household Out-of-Pocket	\$113.7	(7.4)	(6.2)	(5.0)	(2.5)	(16.9)	(12.4)
Employer Plans	138.8	0.0	0.0	29.5	14.9	26.4	10.5
Nongroup Insurance	21.5	(0.7)	(2.9)	(7.0)	(4.3)	(9.8)	(10.8)
Other Private (includes charity care)	16.0	(1.7)	(2.1)	(2.6)	(1.5)	(6.1)	(5.5)
Medicare	93.0	0.0	0.0	(1.8)	(1.2)	(1.8)	(0.3)
Medicaid	39.1	14.7	(3.3)	(2.8)	(1.5)	9.8	(39.1)
Medicaid Buy-In	NA	NA	19.4	NA	NA	17.6	NA
CHAMPUS and Military	6.4	0.0	(1.0)	(0.1)	(0.1)	(0.9)	(1.1)
County Hospitals and Other Welfare	19.2	(2.8)	(1.4)	(2.0)	(1.2)	(7.0)	(8.4)
Insurance Fund ("Pay or Play" Plan)	NA	NA	NA	NA	NA	NA	86.3
Total (Induced demand)	\$447.7	\$2.1	2.4	8.1	2.6	\$11.3	11.3
Increased Reimbursement for Medicaid Services <sup>d/</sup>	NA	NA	NA	NA	NA	NA	7.9

NA Not applicable in policy scenario.

<sup>a/</sup> Includes health benefit payments only. Excludes administrative costs.

<sup>b/</sup> This Medicaid expansion includes raising the eligibility level to the poverty level (185 percent for pregnant women and infants), decoupling eligibility from public assistance, mandating medically needy programs in all states and raising the asset eligibility limit to \$5,000.

<sup>c/</sup> Persons are assumed to participate in either Medicaid or the Medicaid buy-in program during months when they are not insured.

<sup>d/</sup> The NICHC proposal reimbursement levels under the fund would be set at prevailing market levels which will result in an increase in reimbursement for services formerly covered by Medicaid.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

payments, the tax payments some employers face are lower than the premiums required by a mandate.

Each proposal affects the non-group insurance market, with employer mandates having the largest impact. Many persons who currently purchase non-group insurance are not offered employer-based insurance. If employer-based insurance were made available, many of these persons would drop their non-group insurance and opt for employer insurance. Medicaid expansion would have a minimal impact on non-group insurance because most of the uninsured who purchase non-group coverage would not qualify for Medicaid, but the Medicaid buy-in modeled would reduce expenditures for non-group coverage by 13 percent.

The cost of the Medicaid program would increase almost 38 percent under the illustrative Medicaid expansion option. Under the Medicaid buy-in, costs would decrease in the current Medicaid program by \$3.3 billion but the subsidized buy-in program would have expenditures of \$19.4 billion. The decline in base program costs is because some persons who became eligible under spenddown enroll in the buy-in. The large reduction in Medicaid costs under the pay or play proposal reflects the replacement of the program with an insurance fund.

#### 4. Impact on Family Health Expenditures

As discussed above, each proposal to expand health insurance coverage would reduce household out-of-pocket expenses. This section provides more information on the change in expenditures by family income. It also presents information on the impact of these proposals on expenditures by the underinsured.

Table 70 presents the changes in per capita out-of-pocket expenditures among persons who are currently uninsured and underinsured under each policy option. The definition of underinsured is persons with a 5 percent or greater chance of having out-of-pocket expenses in excess of 10 percent of income. Using this definition, 12.2 million Americans would be underinsured

Table 70

**The Number of Uninsured and Underinsured Persons and Average Per Capita Out-of-Pocket Expenses  
for These Persons Under Alternative Health Coverage Proposals**

Policy Options	Persons Uninsured Under Current Policy <sup>a/</sup>		Per Capita Out-of-Pocket Expenses Under Each Option <sup>b/</sup>	
	Persons Remaining Uninsured Under Each Option (in millions)	Persons Remaining Underinsured Under Each Option (in millions) <sup>c/</sup>	Currently Uninsured	Currently Underinsured <sup>c/</sup>
<b>Current Policy</b>	31.5	12.2	\$437	\$482
<b>Medicaid Expansion</b>				
Illustrative Medicaid Expansion <sup>d/</sup>	24.6	10.7	328	381
Medicaid Buy-in	21.2	6.9	325	307
<b>Employer Mandate</b>				
Specified Benefits	6.2	7.0	349	429
Catastrophic Benefits	6.2	10.7	397	450
<b>Employer Mandate with Medicaid Expansion</b>				
Full Participation	0.0	3.7	216	286
Less than Full Participation	2.7	4.0	254	298
<b>Pay or Play</b>	0.0	3.5	248	356

<sup>a/</sup> Persons uninsured throughout the year.

<sup>b/</sup> The underinsured include persons with a 5 percent or greater change of having out-of-pocket health expenses in excess of 10 percent of income.

<sup>c/</sup> Includes all direct payments for personal health care services (excludes premium payments).

<sup>d/</sup> This Medicaid policy extends coverage to persons with monthly income below the poverty level (185 percent for pregnant women), decouples from categorical eligibility, sets the asset eligibility limit at \$5,000, and establishes a medically needy program in all states.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



under current policy. The impact of the options for expanding health insurance on the number of underinsured would range from 3.7 million persons remaining underinsured under the employer mandate with Medicaid expansions (full participation) to 10.7 million persons under an employer mandate with a catastrophic benefit package.

Under all proposals per capita out-of-pocket expenses would be reduced for both the currently uninsured and underinsured. The biggest reduction is in the programs of employer mandates with the specified benefit package and pay or play option. These reduce out-of-pocket spending over 40 percent. The proposal (assuming full participation in Medicaid) reduces per capita spending by the uninsured by over 50 percent. The employer mandate with a catastrophic benefit package, because of its high deductibles, would reduce per capita out-of-pocket spending by less than 10 percent.

Table 71 presents family expenditures by premiums and out-of-pocket payments for each option. Premiums would decrease under all proposals except the employer mandate with a catastrophic benefit package. The largest decrease in premiums would be with the employer mandate with a specified benefit package.

Table 72 presents total family expenditures (premiums plus out-of-pocket payments) for each option for families where all members are uninsured and families where some members are insured. Medicaid expansion options reduce out-of-pocket payments for families where all members are uninsured to a greater extent than families with some insured members. The opposite is true for employer-mandates.

Table 73 presents the change in family premium and out-of-pocket expenditures by family income. For families with incomes below poverty, the greatest decrease in expenditures would occur under the illustrative Medicaid expansion option and the employer mandate proposal with Medicaid expansions. This reduction is largely due to raising the eligibility level for Medicaid to 100 percent of poverty under these options. The Medicaid buy-in would

Table 71

Change in Average Family Premium Payments and Out-of-Pocket Expenditures  
Under Selected Policy Options for Families with Head Under Age 65

	Average Premium Payment Per Family	Average Out-of-Pocket Expenditure Per Family	Average Total Payments Per Family
Current Policy	\$560	\$1,155	\$1,715
Medicaid Expansion			
Illustrative Medicaid Expansion	(4)	(86)	(90)
Medicaid Buy-in <sup>a/</sup>	(19)	(76)	(95)
Employer Mandate			
Specified Benefits	(222)	(62)	(284)
Catastrophic Benefits	21	(32)	(11)
Employer Mandate with Medicaid Expansion			
Full Participation in Medicaid	(163)	(184)	(347)
Less than Full Participation in Medicaid	(218)	(161)	(379)
Pay or Play	(98)	(154)	(252)

<sup>a/</sup> This Medicaid policy extends coverage to persons with monthly income below the poverty level (185 percent for pregnant women), decouples from categorical eligibility, sets the asset eligibility limit at \$5,000, and establishes a medically needy program in all states.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 72

Change in Average Total Family Expenditures  
Under Selected Policy Options for Families with Head Under Age 65<sup>a/</sup>

Change in Family Payments Under Policy Options	Average Total Family Health Expenditures		
	Families Where All Members are Uninsured Under Current Law	Families with Insured Members Under Current Policy	All Families
Current Policy	\$891	\$1,837	\$1,715
Medicaid Expansion			
Illustrative Medicaid Expansion	(181)	(77)	(90)
Medicaid Buy-in <sup>b/</sup>	(174)	(84)	(95)
Employer Mandate			
Specified Benefits	14	(328)	(284)
Catastrophic Benefits	42	(19)	(11)
Employer Mandate with Medicaid Expansion			
Full Participation in Medicaid	(202)	(368)	(347)
Less than Full Participation in Medicaid	(199)	(405)	(379)
Pay or Play	(144)	(267)	(252)

<sup>a/</sup> Total family health expenditures include premium payments by family members and out-of-pocket spending for personal health care.

<sup>b/</sup> This Medicaid policy extends coverage to persons with monthly income below the poverty level (185 percent for pregnant women and infants), decouples from categorical eligibility, sets the asset eligibility limit at \$5,000, and establishes a medically needy program in all states.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

Table 73

Change in Average Total Family Health Expenditures by Family Income  
as a Percentage of the Poverty Line for Families with Head Under Age 65

	All Families	Below Poverty	100%-149% of Poverty	150%-199% of Poverty	200%-299% of Poverty	300% or More of Poverty
Current Policy	\$1,715	\$1,021	\$1,602	\$1,775	\$1,735	\$1,897
Change in Family Health Expenditures Under Selected Policy Options						
Illustrative Medicaid Expansion <sup>b/</sup>	(90)	(267)	(219)	(215)	(41)	(20)
Medicaid Buy-in	(95)	(401)	(378)	(116)	(1)	3
Employer Mandate	(284)	(144)	(243)	(285)	(326)	(308)
Employer Mandate with Medicaid Expansion <sup>c/</sup>	(347)	(550)	(567)	(441)	(272)	(269)
Pay or Play	(252)	(358)	(345)	(458)	(286)	(169)

<sup>a/</sup> Total family health expenditures include premium payments by family members and out-of-pocket spending for personal health care.

<sup>b/</sup> This Medicaid policy extends coverage to persons with monthly income below the poverty level (185 percent for pregnant women and infants), decouples from categorical eligibility, sets the asset eligibility limit at \$5,000, and establishes a medically needy program in all states.

<sup>c/</sup> Assumes all eligible persons participate in the Medicaid program during months where uninsured.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).



significantly reduce expenditures for families with incomes below poverty and between 100 and 149 percent of poverty. Under this option, eligibility levels for Medicaid would remain unchanged, but the premiums would be low enough for families just above the Medicaid eligibility level to afford to purchase the buy-in. For families with incomes above 200 percent of poverty, the employer mandate reduces family expenditures the most, largely because their premium share would be substantially reduced. When an employer mandate is coupled with Medicaid expansion, out-of-pocket expenditures for families with incomes above 200 percent of poverty would be higher than under only an employer mandate. This is because, under the Medicaid expansion assuming full participation, those families are required to enroll and to pay the full cost of the premium.

#### 5. Changes in the Health Care Delivery System

These proposals might have a wide range of potential effects on the health care system. We examined two: 1) changes in charity care and bad debt in hospitals; and 2) changes in usual source of care for physician services.

Table 74 presents the changes in charity care and bad debt (uncompensated care) under each of the proposals. The two universal coverage proposals would produce the largest reduction in uncompensated care, largely because they cover the most people. Under these options uncompensated care would be reduced from \$9.6 billion to \$3.5 and \$4.1 billion, respectively. The employer mandate with a catastrophic benefit package would have little impact on uncompensated care, only reducing it by \$1.5 billion. This is because, while a catastrophic plan would cover the high cost hospital bills that would have been uncompensated care, a large portion of uncompensated care is due to many small bills, especially for emergency room and outpatient services.

Even the proposals that would cover all the uninsured only reduce uncompensated care costs by less than one-half. This is because approximately one-third of uncompensated care costs are in the form of unpaid deductibles

Table 4  
Impact of the Policy Options on Uncompensated Care  
(in billions)

Option	Total Hospital Uncompensated Care Under Current Policy	Reduction in Uncompensated Care	Total Remaining Uncompensated Care
Illustrative Medicaid Expansion <sup>a/</sup>	9.6	(1.7)	7.9
Medicaid Buy-In	9.6	(2.1)	7.5
Employer Mandate	9.6	(2.6)	7.0
Employer Mandate with Catastrophic Benefits	9.6	(1.5)	8.1
Employer Mandate with Medicaid Expansion <sup>b/</sup>	9.6	(6.1)	3.5
National Leadership Commission on Health Care	9.6	(5.5)	4.1

<sup>a/</sup> This Medicaid policy extends coverage to persons with monthly income below the poverty level (185 percent for pregnant women and infants), eliminates categorical requirements, sets the asset eligibility limit at \$5,000, and establishes a medically needy program in all states.

<sup>b/</sup> Assumes all eligible persons participate in the Medicaid program during months when they are uninsured.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

and coinsurance from persons with insurance. These uncompensated costs would remain. Further, some of the uninsured obtaining coverage would generate some uncompensated care costs as well.

A second potential shift in health care delivery that might emerge as a result of proposals to expand insurance is to shift the usual source of care of the newly insured toward physicians in private practice and away from hospital outpatient departments and emergency rooms which usually do not provide ongoing, coordinated primary care. While a precise estimate of this shift in site of care cannot be determined, data from the Robert Wood Johnson Foundation Access Survey indicate that a majority of both the insured and uninsured consider a private physician to be their usual source of care. The uninsured, however, are more likely than the insured to rely on hospital-based providers. As more of the uninsured become covered, we would expect to see a shift in site of care away from hospital-based providers and toward private physicians.

The type of insurance individuals have can affect their site of care. Publicly insured persons rely on hospital-based providers as their usual source of care to a greater extent than privately insured persons. Therefore, expanding coverage under Medicaid may not result in a shift from hospital-based providers to private physicians as would expanding coverage under employer-based insurance.

## 6. Impact on Employment and Wages

Under an employer mandate proposal employers may respond to the increase in costs by either raising the prices of goods and services they produce or by reducing other forms of employee compensation. The consensus among economists, however, is that in the long-run few employers would not respond by raising prices. This is largely because many of the firms affected by this proposal are small firms, many of whom are in the service and retail trade industries, which typically have little control over the prices they can

charge in their markets. Employers are more likely to respond to the increase in costs by changing some level or mix of employment or wage rates.

Most economists believe that employers will respond to the increase in costs by reducing wage levels or other forms of employee compensation (e.g., pensions and life insurance) rather than reducing their workforce. However, employer mandates could result in some loss of jobs for those employed at or near the minimum wage. This is because the minimum wage law prohibits employers from adjusting wages below this level.

#### 7. Target Efficiency of the Proposals

If the principal goal of these efforts is to insure the uninsured, the target efficiency of alternative policies can be defined in terms of the percentage of persons affected by the proposal who were uninsured under current law. As we have seen throughout this study, the various proposals to expand health insurance coverage tend to alter the sources of coverage for currently insured persons in addition to covering persons without health insurance coverage. Therefore, the relative target efficiency of the various proposals could be evaluated in terms of the options that minimize their impact on persons who are already insured and concentrate resources on the currently uninsured population.

The shifts in coverage for persons who now have insurance are attributed to two factors. First, under any plan providing public or employer subsidized health insurance, eligible persons who now participate in non-group insurance plans where they bear the full cost of coverage, will have an incentive to terminate this coverage and participate in the subsidized plan. Second, many of those who become covered under these proposals could participate without forgoing their eligibility for other forms of insurance. For example, persons eligible for Medicaid expansions can enroll and use Medicaid as a secondary payor even if they have coverage under Medicare or an employer plan. Similarly, employer mandates apply to all workers even if they are



covered under Medicare or Medicaid. Thus, persons may shift from Medicaid into employer-based insurance.

Using this definition of target efficiency, the employer mandate appears to be the most efficient of all of the proposals examined. About 50 percent of those who become covered under the employer mandate are persons who would otherwise have been uninsured under current policy (Table 75). By comparison, under the pay or play plan, only about 30 percent of those who become covered under the proposal would have been uninsured. This lower degree of target efficiency under pay or play is explained in part by the inter-employer equity provisions which are intended to reallocate responsibility for insuring workers and dependents among employers more equitably. Without the limits on spousal waiver, the target efficiency of the two approaches is comparable.

In general, the employer mandate options are more target efficient than the Medicaid expansion options. Under the illustrative Medicaid expansion 40 percent of those who become covered were previously uninsured. This proportion increases to 49 percent under the Medicaid buy-in. This reflects the fact that the premium contribution required under the buy-in plan tends to limit participation only to those without coverage from other sources while Medicaid expansions are available to all eligible persons generally with no premium payment.

This definition of target efficiency is in many ways too narrow to measure the effectiveness of these proposals in achieving other objectives. For example, many low income families would see their premium payments reduced and their health insurance benefits would be improved. Also, many of the changes in sources of financing of coverage are intended to achieve greater equity in financing of health care and should not be treated as target inefficiency.

An alternative measure of target efficiency is the distribution of new government expenditures across selected demographic groups. For example,

Table 75

## Target Effectiveness of Government Expenditures Under Alternative Policies

	Persons Whose Source of Coverage is Modified (in millions)	Affected Persons Who Were Uninsured Under Current Law (in millions)	Percent of Affected Persons Who Were Uninsured
Illustrative Medicaid Expansion <sup>a/</sup>	17.1	6.9	40.3%
Medicaid Buy-In <sup>b/</sup>	20.7	10.2	49.3
Employer Mandate with Specified Benefits	50.4	25.3	50.1
Employer Mandate with Medicaid Expansion <sup>c/</sup>	74.7	31.5	42.2
Pay or Play	105.2	31.5	29.9

<sup>a/</sup> Total family health expenditures include premium payments by family members and out-of-pocket spending for personal health care.

<sup>b/</sup> This Medicaid policy extends coverage to persons with monthly income below the poverty level (185 percent for pregnant women and infants), decouples from categorical eligibility, sets the asset eligibility limit at \$5,000, and establishes a medically needy program in all states.

<sup>c/</sup> Assumes all eligible persons participate in the Medicaid program during months where uninsured.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (EBSM).

the Medicaid expansion is more effective at targeting government expenditures on low-income groups than are employer mandates. About 71 percent of all government funding under this proposal would be received by persons with incomes below \$10,000 (Table 76).

In contrast, under the employer mandate options, government expenditures are measured in terms of tax revenue losses (i.e., tax expenditures) attributed to the deductibility of employer health plan benefit payments in determining corporate income tax liability. Only about 23 percent of this tax expenditure is directed to persons with incomes below \$10,000 under the employer mandate (27 percent under the catastrophic plan). However, if the employer mandate were implemented together with Medicaid expansions, about 58 percent of government expenditures, including tax expenditures for the employer mandate, Medicaid payments, and premium subsidies under the buy-in program, would be directed to persons with incomes below \$10,000. Under the pay or play plan only about 40 percent of all new government expenditures under the insurance fund created under the plan would be received by this lowest income group.

The distribution of government expenditures under the various proposals differs across age groups. About 13.4 percent of government spending under the Medicaid expansion would be received by children under age 18. By comparison, about 11.7 percent of government funding would be directed towards children under the buy-in plan and about 14.6 percent of tax expenditures under the employer mandate would be directed to children (Table 76). The employer mandate would also direct about seven percent of government tax expenditures to persons age 65 or older compared with only about 1.5 percent under the Medicaid expansion proposals.

The employer mandate is more effective at directing government expenditures to the uninsured than are any of the other proposals. About 61 percent of tax expenditures under the employer mandate would benefit persons who would otherwise be uninsured under current policy. By comparison, only about 49 percent of government expenditures under the Medicaid expansion would

Table 76

## Percentage of New Government Expenditures Received by Group Under Selected Policy Options

	Illustrative Medicaid Expansion <sup>a/</sup>	Medicaid Buy-In <sup>b/</sup>	Employer Mandate <sup>c/</sup>		Employer Mandate with Medicaid <sup>d/</sup> Expansion	Pay or Play
			Specified Benefits	Catastrophic Benefits		
<b>Annual Family Income</b>						
Less Than <\$10,000	70.6%	66.6%	22.8%	26.6%	57.9%	40.4%
\$10,000-\$14,999	17.7	20.3	18.5	18.8	19.0	22.1
\$15,000-\$19,999	3.1	7.8	10.6	11.6	12.2	12.5
\$20,000-\$29,999	5.1	4.7	22.2	26.7	5.4	8.9
\$30,000-\$39,999	1.8	0.6	10.3	5.7	2.2	8.1
\$40,000-\$49,999	1.7	0.0	8.0	3.3	1.6	4.1
\$50,000 or more	0.0	0.0	7.6	7.3	1.7	3.9
<b>Age</b>						
<18	13.4	11.7	14.6	7.2	13.8	9.8
18-24	26.5	26.8	15.8	17.9	8.3	25.7
25-34	19.2	24.1	30.9	31.7	26.0	24.3
35-44	12.5	13.6	14.6	13.5	10.8	10.9
45-54	9.1	9.1	13.9	12.9	11.4	9.1
55-64	17.6	13.1	9.5	16.6	20.3	16.0
65+	1.7	1.6	7.0	0.2	9.4	4.2
<b>Insured Status Under Current Law</b>						
Insured Sometime in Year	51.2	42.4	38.6	36.6	49.9	67.0
Uninsured All Year	48.8	57.6	61.4	63.4	50.1	33.0
<b>Total</b>	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>Total Amount</b> (in millions)						

<sup>a/</sup> Includes federal and state payments for benefits and administration for persons who become newly eligible under the illustrative Medicaid expansion proposal.

<sup>b/</sup> Includes federal and state premium subsidy payments for benefits provided under Medicaid buy-in.

<sup>c/</sup> Includes federal tax expenditures for employer health benefits deductions.

<sup>d/</sup> Includes federal tax expenditures for tax deductions for employer benefits payments and state and federal expenditures for benefits and administration under the expanded Medicaid program.

Source: Lawin/ICF estimates using the Health Benefits Simulation Model (HBSM).

**Lawin/ICF**



be received by the uninsured and only about 57 percent of benefit subsidies under the buy-in program would be directed to the uninsured. The least target efficient of the various proposals is the pay or play plan which directs only about 33 percent of expenditures under the insurance fund created under the plan to persons who would have been uninsured under current policy. This understates the proportion of expenditures targeted to the uninsured because it includes the expenditures associated with transferring current Medicaid enrollees into the fund. When the expenditures for the current Medicaid program are removed, the pay or play approach directs about 58 percent of expenditures to the uninsured.

#### E. ADMINISTRATIVE FEASIBILITY

Administrative feasibility and administrative burden are major considerations in reviewing options. A large administrative burden increases program costs and may make it difficult to successfully achieve the goals of the program. In this section we discuss the relative administrative burden of the options to expand insurance coverage along three dimensions: 1) the extent they require new administrative structures; 2) the extent they entail coordination of benefits; and 3) the extent they increase enrollment. While we do not provide estimates of the cost of administering each option, we discuss which option is likely to result in the highest administrative cost overall and by payor based on the relative burden posed by creating new administrative structures and by enrolling additional persons.

##### 1. New Administrative Structures

Some options can be administered within existing program structures; others require a new administrative agency or the addition of new administrative functions within an existing agency. Among the Medicaid initiatives, the Medicaid expansion options can be administered largely within the existing program structure. The program currently determines eligibility based on applicant characteristics and financial resources, and modifying these parameters would not require major administrative changes. Therefore, options

to raise income eligibility levels for all persons or for certain population groups, such as pregnant women and infants, would be the easiest to integrate into the current program structure. In contrast, the Medicaid buy-in option represents a departure from the current Medicaid structure and poses new administrative demands on states. They would need to adapt their Medicaid programs to incorporate many of the administrative functions of traditional insurers, such as collecting premiums, copayments, and deductibles, and billing recipients.

Extending employer-based insurance through mandates or tax incentives would require establishing a new administrative agency or adding administrative functions to existing agencies. Under the employer mandate three new administrative functions would be required: 1) states would be required to monitor employers to assure that they are providing insurance that meets the specified benefit standards; 2) states would be required to review employer applications for subsidy and administer the subsidy program; and 3) employers would be required to submit a description of their plans and evidence that all eligible employees are enrolled.

The pay or play proposal would impose the greatest administrative demands in terms of new administrative functions. Under this plan a new administrative agency would be required to monitor the tax incentive program and administer the public fund. The state would be required to monitor employers to assure that they are providing insurance that meets the requirements or are paying the tax; it would also be required to set the tax rate and collect the tax. This agency or a separate agency would be required to administer the public fund which entails setting benefits, determining eligibility, collecting premiums, copayments, and deductibles, and coordinating enrollment with employer-based insurance.

## 2. Coordination of Benefits

One of the most difficult administrative issues could prove to be coordination of benefits for individuals who move in and out of various health plans during the year. Several of the proposals analyzed in this study

limited individual cost sharing to given deductible and coinsurance amounts, and placed a limit on total out-of-pocket expenditures. For example, the Kennedy-Waxman employer mandate, the Medicaid buy-in proposal, and the NLCHC plan all place a limit on the amount of cost sharing that a family would pay in a year. Limiting family out-of-pocket expenditures is likely to be difficult to administer in cases where individuals change their source of coverage during the year.

For example, the employer mandate with Medicaid expansions seeks to increase the number of employers offering health insurance while providing Medicaid or Medicaid buy-in coverage for persons during periods when they are not covered by an employer plan. Thus, persons who are employed only part of the year would be covered under an employer plan while working, and covered under Medicaid during other months of the year. Unless benefits provided under the employer plan and the Medicaid buy-in plan are coordinated, the individual would face two deductibles during the year; one on the employer plan and another under the buy-in plan. Similarly, unless cost sharing under the first plan is credited against the cost sharing limits under the second plan, it would be possible for an individual to have total cost sharing expenses during the year well in excess of the annual out-of-pocket limit intended under the policy.

This coordination of benefits issue is likely to be particularly important among seasonal and low-wage workers who typically move in and out of employment throughout the year. In fact, nearly one-half of all workers and dependents who would obtain coverage under the employer mandate with Medicaid expansions would be employed for only part of the year and potentially would be covered under Medicaid for at least part of the year.

Coordination of benefits is further complicated because many workers would be employed on several jobs during the year. Without coordination of benefits among employers, workers will face a new deductible and cost sharing limit in each job they enter. Workers who frequently change employers during the year might never exceed the deductible under any one plan, and could end



up paying substantial premiums yet financing all their care out-of-pocket. Although it is possible to require employers to credit individuals for cost sharing under other plans for the year to date, this is likely to add substantially to administrative costs for both employers and the government-sponsored plan.

### 3. Enrollment

The administrative burden associated with enrollment can be determined by analyzing the number of transitions in coverage resulting from part-year enrollment. For example, a person may be enrolled in employer-based coverage for 4 months, Medicaid for 6 months, and then regain employer-based coverage, experiencing two transitions in coverage. This entails added administrative burden in terms of enrolling and terminating coverage and determining eligibility for Medicaid. Table 77 presents the number of times individuals would be certified for coverage under government sponsored insurance during the year. The number of transitions is greatest under the universal coverage options. This is because individuals would be covered by insurance throughout the year. The employer mandate with Medicaid expansions (assuming full participation) and the pay or play proposal would result in 26.6 million and 23.4 million transitions per year, respectively. In contrast, the illustrative Medicaid expansion package and the Medicaid buy-in would result in 6.5 million and 8.2 million transitions per year, respectively.

Earlier in this report we described the effect on enrollment of using different accounting periods to determine eligibility and different eligibility certification periods to determine how long persons remain enrolled. Variations in accounting and recertification periods would also affect the number of transitions under an option. Monthly eligibility determination with monthly certification would produce the greatest number of transitions while a monthly accounting period with 12-month recertification would produce the fewest transitions.



Table 77

The Number of Times Individuals Are Certified for  
Coverage Under Government Sponsored Insurance During Year  
Under Selected Health Insurance Expansion Proposals<sup>a/</sup>

	Number of Certification Actions Per Year (in millions)
Illustrative Medicaid Expansion Proposal <sup>b/</sup> (raise eligibility to poverty level)	6.5
Medicaid Buy In <sup>c/</sup>	8.2
Medicaid Expansions Under Employer Mandate (assumes full participation in Medicaid) <sup>d/</sup>	26.6
Pay or Play <sup>e/</sup>	23.4

- a/ Each time an individual enters a government sponsored program during the year is counted as a certification action.
- b/ Persons with incomes below 185 percent of poverty are eligible for buy-in.
- c/ This Medicaid expansion includes raising the eligibility level to the poverty level (185 percent for pregnant women and infants), decoupling eligibility from public assistance, mandating medically needy programs in all states and raising the asset eligibility limit to \$5,000.
- d/ Persons are required to participate in either Medicaid or the Medicaid buy-in program during months where persons are not insured.
- e/ Persons are covered under the fund in months where they do not have insurance from other sources.

Source: Lewin/ICF estimates using the Health Benefits Simulation Model (HBSM).

We would expect administrative costs to be greater with options that produce a large number of transitions because of the added cost of enrolling and disenrolling persons from coverage. The employer mandate with Medicaid expansion and the pay or play proposal would have the highest administrative costs. However, the pay or play proposal also simplifies administration by guaranteeing coverage of the uninsured through the public fund. This guarantee eliminates lengthy eligibility processes, but still requires administrative costs for the determination of premiums, deductibles, and coinsurance.

#### F. CONCLUSION

The results of this analysis of alternative approaches for extending health insurance to the uninsured confirm the issues highlighted at the end of Part One. Options are not easily targeted only to the uninsured. Those choosing among them must balance concerns about target efficiency against the proportion of the uninsured who receive coverage. Those proposals which cover the greatest number of the uninsured also affect large numbers of insured persons. These proposals vary in the number of uninsured covered and the extent to which they create shifts in coverage among those who are currently insured.

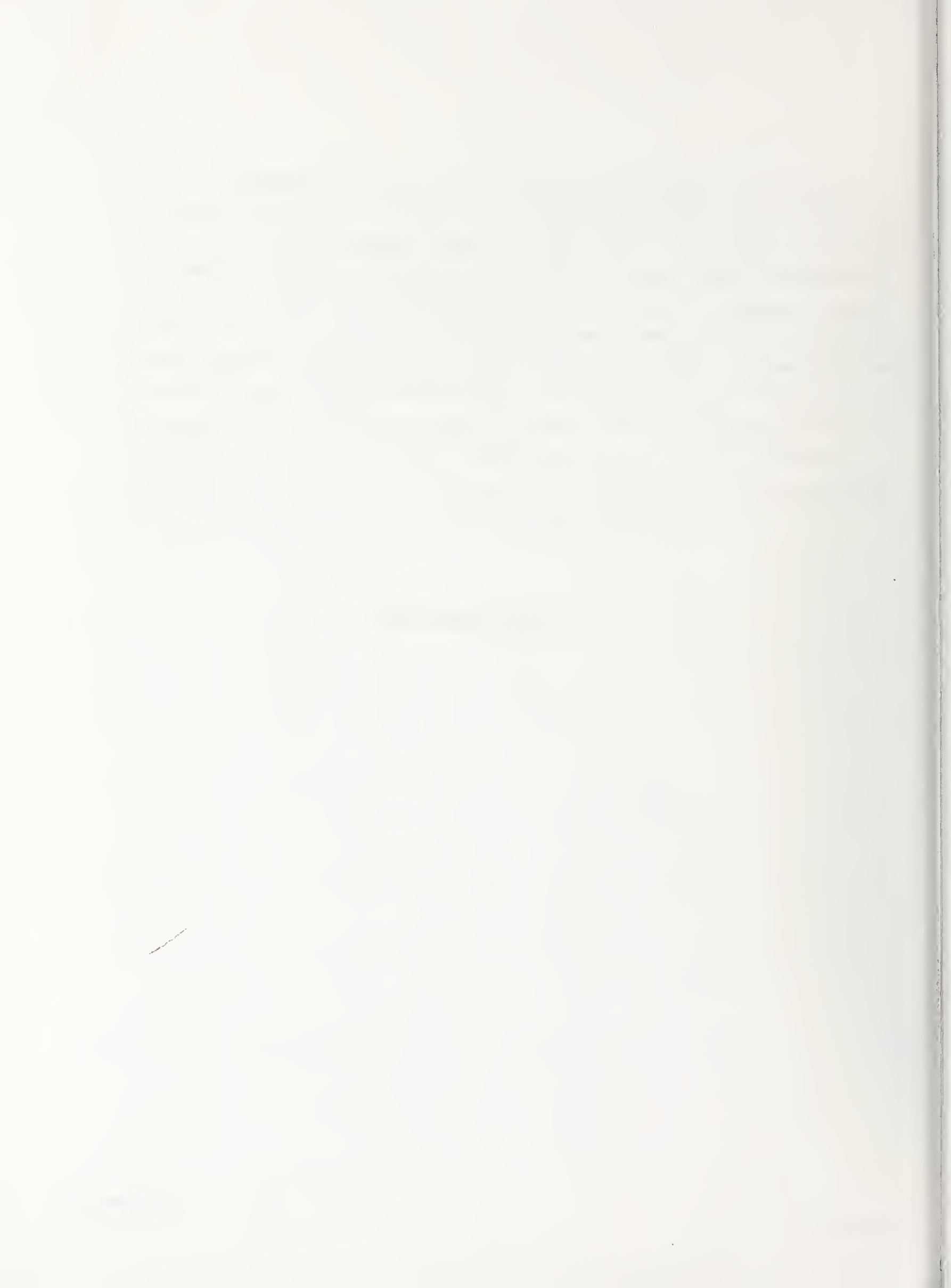
Options to expand coverage involve substantial refinancing of current health care spending. Under an employer mandate and pay or play approach which would cover all persons the total induced demand for health care would cost \$11.3 billion. However, the costs to particular payors are substantially above this amount. The extent to which the burden of this refinancing is borne more by government or employers depends on the option and financing strategy adopted.

Likewise, these proposals vary to the extent they target low income persons. Medicaid expansion options are targeted to low income populations. Employer mandates, while covering a large number of low income persons, also affect a large cohort of higher income persons.

Proposals also vary in the administrative demands they impose and who would have to address them. The employer mandate with Medicaid expansion and the pay or play proposals would be likely to have the highest administrative costs. Assuring universal and continuing coverage and coordination of benefits in a system that relies on both employer-based coverage and public coverage as well as effective transition between them will impose substantial administrative demands. However, these options also cover the greatest number of people. These added administrative costs need to be weighed against the increased benefits from the program. Indeed, whether considered in terms of the number of uninsured covered, refinancing of care, or administrative complexity, choosing among these options requires decisions to be made about the relative priority of important but conflicting objectives.

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